TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

1

02430

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02416

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR	
WILSON	ELISHA	ARBAUGH	Feb	15	1968	5 40	PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN
MALE	WHITE	MARCH 31 1889	78 YRS.				

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
CARROLL CO. MD	U.S.A.		CARROLL CO. MD. Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12a. USUAL OCCUPATION (Kind of wark done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
WESTMINSTER	CARROLL CO. GEN. HOSP.	SHIPPING CLERK	PRINTING CO.

13a. USUAL RESIDENCE (Where deceased lived, if institutian: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MARYLAND	CARROLL	WESTMINSTER	YES ☑ NO ☐	127 E. MAIN ST.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
NOAH	W.	ARBAUGH	SARAH	R.	FLATER

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
	276-01-1973A	MRS CLARENCE A. LEPPO SR.	FINKSBURG RD#1 Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) congestive heart failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 month

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic Heart Disease — several years

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Carcinoma of the prostate metastatic

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☑	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this haspital) attended the deceased from Feb 15, 1968, to Feb 15, 1968, that (I) (we) last saw the deceased alive an Feb 15, 1968, and that in (my) (aur) apinian death accurred an the date and haur and fram the causes stated abave, (I) (~~we~~) (did) (~~did not~~) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS. ☐	MED. DIRECTOR ☐	STAFF PHYS. ☐	22c. DATE SIGNED
John S. Harshey	MD				2/15/68

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
JOHN S. HARSHEY M.D.	8 Bruchon St. Westminster, Md.

23a. ~~BURIAL~~, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
CREMATION	2/19/68	Fort Lincoln Cemetery	Bladensburg Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. RECD BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
J. E. Myers Jr.	Westminster, Md	FEB 19 1968	Charles Jordan

1

FOR STATE HEALTH DEPT.

02431

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02417

1. DECEASED-NAME (Type or Print)	First	Middle	Last
	BARRY	WAYNE	BABYLON

2a. DATE OF DEATH KNOWN [X] ESTIMATED [ ] Month 2 Day 26 Year 1968 — 2b. HOUR 6:20 A.M.

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
Male	White	Sept. 29, 1967	YRS. 4-1/2		

2c. DATE PRONOUNCED DEAD Month February Day 26, Year 1968 — 2d. HOUR 6:20 A.M.

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
Maryland	U S A	NEVER MARRIED [X]	CARROLL Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Sykesville	Haight Funeral Home	None	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Carroll	Sykesville	YES [ ] NO [X]	Rt.3 Box 183

14. FATHER'S NAME First / Middle / Last	15. MOTHER'S MAIDEN NAME First / Middle / Last
Unknown	Renae - Griffith

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No —	—	MR. JAMES Willis - Sykesville, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Interstitial pneumonitis (SDII) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
484 X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
525 X

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES [X] NO [ ]

21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State

22a. **I certify** that I took charge of the remains described above, held an Autopsy [X], Inspection [ ], Inquiry [ ], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE Charles S. Springate M.D.
EXAMINER'S NAME (Type) Charles S. Springate, M.D.
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
DEPUTY MEDICAL EXAMINER [ ]
ADDRESS (Street, city, town, or county)
22b. DATE SIGNED February 26, 1968

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	2-28-68	LAKE View MEMORIAL	Sykesville Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Harry W. Haight	Sykesville, Md.	FEB 29 1968	Charles Jungen

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M REV. 1/68

71284349

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02432 02418

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First: Clarence EDGAR	Middle	Last: Bachman	2a. DATE OF DEATH Month: 2 Day: 17 Year: 68	2b. HOUR 8 05 M	
3. SEX: male	4. RACE: white	5. DATE OF BIRTH: 11-17-1888	6. AGE (In years last birthday): 79 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (State or foreign country): Md Bachmans Valley	7b. CITIZEN OF WHAT COUNTRY?: Westminster, USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐	9. COUNTY OF DEATH: Carroll COUNTY Md.		
10. CITY OR TOWN OF DEATH: Manchester, Md.	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): Evergreen Nursing 128 N. Main St Home	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Farmer	12b. KIND OF BUSINESS OR INDUSTRY: —		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence, before admission) STATE: Pa	13b. COUNTY: U.S.A.	13c. CITY OR TOWN: Gettysburg Pa.	13d. INSIDE CITY LIMITS? YES ☐ NO ☑	13e. STREET AND NUMBER: Route #3. Knoxlyn Rd	
14. FATHER'S NAME First: Alfred C.	Middle	Last: Bachman	15. MOTHER'S MAIDEN NAME First: Suzanne	Middle	Last: Mathias
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown): No (If yes give war or dates of service): —	16b. SOCIAL SECURITY NO.: 217-36-4367	17. INFORMANT (Daughter-in-law): Helen Bachman	Address: 190 Franklin Ave Westminster, Md.		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Metastatic Adenocarcinoma liver — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 4 MON
1538
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b): Carcinoma in polyp colon — 4 MON
DUE TO, OR AS A CONSEQUENCE OF (c): —

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
1538

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☑	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	

22a. **I certify** that (I) (this hospital) attended the deceased from 12/3, 1967, to Feb 17, 1968, thot (I) (we) last saw the deceased olive on 2/16/1968, and that in (my) (our) opimon deoth occurred on the dote ond hour ond from the couses stated abave. (I) (we) (did) (did nat) view the bady after death.

22b. SIGNATURE: W. H Foard MD	DEGREE: ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐	22c. DATE SIGNED: 2/17/68	
22d. PHYSICIAN'S NAME (Type): W. H Foard M.D	22e. ADDRESS: Manchester, Md 21102		

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL	23b. DATE: FEB 20, 1968	23c. NAME OF CEMETERY OR CREMATORY: ST. BENJAMINS-KRIDERS	23d. LOCATION (City or Town): WESTMINSTER	(County): CARROLL (State): MD.
24. FUNERAL DIRECTOR: Thomas G. Saffell	ADDRESS: WESTMINSTER, MD	25a. REC'D BY REGISTRAR DATE: FEB 19 1968	25b. REGISTRAR'S SIGNATURE: [illegible]	

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02433 — 02419

1. DECEASED-NAME (Type or print): First: Elwood; Middle: Stigers; Last: BARNHART
2a. DATE OF DEATH: Month Day Year: February 18, 1968
2b. HOUR: 8:45a M
3. SEX: male
4. RACE: white
5. DATE OF BIRTH: 12-19-1899
6. AGE (In years last birthday): 68 YRS. IF UNDER 1 YEAR: MONTHS, DAYS. IF UNDER 24 HRS.: HOURS, MIN.
7a. BIRTHPLACE (State or foreign country): Maryland
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. COUNTY OF DEATH: Carroll Md.
10. CITY OR TOWN OF DEATH: Sykesville
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): Springfield State Hosp.
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Farmer - retired
12b. KIND OF BUSINESS OR INDUSTRY:
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence, before admission) STATE: Maryland
13b. COUNTY: Howard / Carroll
13c. CITY OR TOWN: Woodbine
13d. INSIDE CITY LIMITS? YES [ ] NO [X]
13e. STREET AND NUMBER:
14. FATHER'S NAME First Middle Last: Stillwell E. Barnhart
15. MOTHER'S MAIDEN NAME First Middle Last: Mary Elizabeth Mann
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): no
16b. SOCIAL SECURITY NO.: 218-12-2686
17. INFORMANT Address: Springfield State Hosp., Sykesville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Aspiration Pneumonia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: hours
7070
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last. 715 x
DUE TO, OR AS A CONSEQUENCE OF (b): Pyogenic Meningitis from Infected dicubitus — Days
DUE TO, OR AS A CONSEQUENCE OF (c): ulcer that resulted in septicemia — Days.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
CBS assoc. with cerebral arteriosclerosis without qualifying phrase.

19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES [X] NO [ ]
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medicol exominer)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While [ ] at work Not while [ ] at work
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County Stote

22a. I certify that (I) (this hospital) attended the deceased from 9-29-67, 19____, to 2-18-68, 19____, that (I) (we) last saw the deceased olive on 2-18-68 19____, and thot in (my) (our) opinian death occurred on the date and hour and fram the causes stated above, (I) (we) (did) (did nat) view the bady after death.

22b. SIGNATURE: Suha Ozgun. DEGREE: ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS. [X]
22c. DATE SIGNED: 2-18-68
22d. PHYSICIAN'S NAME (Type): Suha Ozgun, M.D.
22e. ADDRESS: Springfield State Hospital Sykesville, Maryland 21784

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 2/21/1968
23c. NAME OF CEMETERY OR CREMATORY: Broadfording Cemetery
23d. LOCATION (City or Town) (County) (Stote): Washington Co., Md.
24. FUNERAL DIRECTOR ADDRESS: C. M. Waltz, Box 241, Sykesville, Md.
25a. REC'D BY REGISTRAR DATE: FEB 21 1968
25b. REGISTRAR'S SIGNATURE: Charles Suggs

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physicion and completely filled in by the funeral director, page 3 should be detached for use as the buriol-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to buriol, cremation, or removol, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02434

CERTIFICATE OF DEATH

02421

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
Harry	Wright	Barrick	2	4	68	6 30 M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 1 YEAR DAYS	IF UNDER 24 HRS. HOURS	IF UNDER 24 HRS. MIN.
Male	White	February 4, 1881	87 YRS.				

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
Maryland	U.S.A.	MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	Carroll Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Westminster	Carroll County Gen. Hosp.	Farmer	Own farm

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Carroll	Westminster	YES [ ] NO [X]	Route # 7

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Charles	J.	Barrick	Emma		Eichelberger

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
No	220-34-6897	Mrs. Carrie Barrick, Westminster, Md. R # 7

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CEREBRAL VASCULAR ACCIDENT — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 8 DAYS
4369
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(b) CEREBRAL ARTERIOSCLEROSIS — YEARS
DUE TO, OR AS A CONSEQUENCE OF
(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
331X PNEUMONITIS - LLL

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [✓]	

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I **certify** that (I) (this hospital) attended the deceased from 1/27, 1968, to 2/4, 1968, that (I) (we) last saw the deceased alive on 2/4 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Vincent J. Fiocco Jr.	MD	[✓]	[ ]	[ ]	2/4/68

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Vincent J. Fiocco, Jr.	8 Anchor Street, Westminster, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Feb. 7, 1968	Mt. Tabor Cemetery	Rocky Ridge, Frederick, Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. RECD BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
John H. Skiles C.O.Fuss & Son	Taneytown, Maryland	FEB 6 1968	Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02435

CERTIFICATE OF DEATH

02421

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
GEORGE	CLINTON	BOSTIAN	2	24	68	11:45 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.
MALE	WHITE	1-1-1876	92 YRS.				

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
MARYLAND	U.S.A.		CARROLL Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
SYKESVILLE	PULLEN NURSING HOME	CARPENTER	WOOD

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET AND NUMBER
MARYLAND	FREDERICK	JOHNSVILLE		—

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
JAMES	BOSTIAN		URSULA	NULL	

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
NO	217-16-2838	WM C BOSTIAN	UNION BRIDGE RURAL MD

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Pulmonary thrombosis	24 hours
DUE TO, OR AS A CONSEQUENCE OF (b)	Chr. heart failure	2 yrs.
DUE TO, OR AS A CONSEQUENCE OF (c)	Arteriosclerotic Cardiovascular disease	20 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4129

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

4221 Arterial thrombosis Rt femoral artery

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Manth Doy Year 19	21c. HDW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street ar R.F.D. Na.	City ar Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from Feb 16, 1968, to Feb 24, 1968, that (I) (we) last saw the deceased alive an Feb 24 1968, and that in (my) (our) apinion death accurred an the dote and hour and fram the couses stated above, (I) (we) (did) (did not) view the body ofter death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS. ☒	MED. DIRECTOR ☐	STAFF PHYS. ☐	22c. DATE SIGNED
Sani Okutman					2-25-68

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Sani Okutman	Sykesville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	2/27/68	LUTHERAN	UNIONTOWN MD

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
D.N. Hartsler & Sons	Union Bridge	FEB 27 1968	Charles Yingling

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, ar removal, and in any event, within 72 haurs after death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02436 02422

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, ar removal, and in any event, within 48 hours after death.

1. DECEASED-NAME (Type or print) First	MELVIN	Middle ARTHUR	Last BOWERS
2a. DATE OF DEATH Month Day Yeor	FEBRUARY 20, 1968	2b. HOUR	9:10 A M
3. SEX	Male		
4. RACE	White		
5. DATE OF BIRTH	9-19-1883		
6. AGE (In yeors last birthday)	84 YRS.	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
7o. BIRTHPLACE (State or foreign country)	Pennsylvania		
7b. CITIZEN OF WHAT COUNTRY?	U.S.A.		
8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐			
9. COUNTY OF DEATH	Carroll Md.		
10. CITY OR TOWN OF DEATH	Sykesville		
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	Springfield State Hospital		
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	Factory Worker		
12b. KIND OF BUSINESS OR INDUSTRY			
13o. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	Maryland		
13b. COUNTY	Carroll		
13c. CITY OR TOWN	Sykesville		
13d. INSIDE CITY LIMITS? YES ☐ NO ☒			
13e. STREET AND NUMBER	Rt. #4 Sweet Air Estates		
14. FATHER'S NAME First	Unk.	Middle	Last
15. MOTHER'S MAIDEN NAME First	Unk.	Middle	Last
16o. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	No		
16b. SOCIAL SECURITY NO.	213-05-1590-A		
17. INFORMANT Address	Records, Springfield State Hospital		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Years

412.9

Conditians, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)

4221

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ DR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Manth Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Nat while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.	21f. LOCATION Street or R.F.D. No.	City or Town / County / State

22o. **I certify** that (I) (this hospital) attended the deceased from 2-9-68, 19___, to 2-20-68, 19___, thot (I) (we) last saw the deceased ~~alive~~ on 2-20-68 19___, and that in (my) (our) opinian death occurred an the date and haur and ~~from~~ the couses stated above, (I) (we) (did) (did not) view the body ofter death.

22b. SIGNATURE	Octavio A. Ruiz M.D.	ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒	22c. DATE SIGNED 2-20-68
22d. PHYSICIAN'S NAME (Type)	Octavio A. Ruiz, M. D.	22e. ADDRESS	Springfield State Hospital Sykesville, Maryland 21784

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town)	(County)	(State)
BURIAL	2-22-68	Evergreen Memorial	Finksburg		Md.
24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE		
Harry W. Haight	Sykesville, Md.	FEB 26 1968	Charles Jones		

VR A15 (4) 30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02437 02423

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

1. DECEASED-NAME (Type or print)	First: ~~Gwendolyn~~ Gwendolyn	Middle: Patricia	Last: BRATHUHN	2a. DATE OF DEATH Month: February	Day: 19	Year: 1968	2b. HOUR: 9:30 P.M.
3. SEX: Female	4. RACE: WHITE	5. DATE OF BIRTH: MARCH 17 1915	6. AGE (If years last birthday): 52 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.		
7a. BIRTHPLACE (State or foreign country): IOWA	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: Carroll Md.				
10. CITY OR TOWN OF DEATH: HAMPSTEAD MD	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MAIN Street	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): House wife	12b. KIND OF BUSINESS OR INDUSTRY: Home				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland	13b. COUNTY: Baltimore	13c. CITY OR TOWN: Reisterstown	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	13e. STREET AND NUMBER: Dover Road RFD #1			
14. FATHER'S NAME First: Unknown	Middle	Last: Wheeler	15. MOTHER'S MAIDEN NAME First: Unknown	Middle	Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown): no (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 220-32-5300	17. INFORMANT: Thomas BRATHUHN	Address: Reisterstown Md.				

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral hemorrhage — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Suddenly
DUE TO, OR AS A CONSEQUENCE OF (b): Hypertension (Malignant) — 2-3 years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
445 X

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
—	—		—

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
		—	—		

22a. **I certify** that (I) (this hospital) attended the deceased from 2-14- , 1967, to 2-19 , 1968, that (I) (we) last saw the deceased alive on 2-19 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Joseph E. Bush		[X]	[ ]	[ ]	2/19/68

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Joseph E. Bush MD	HAMPSTEAD Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Feb. 22, 1968	Pleasent Grove Cemetery	Boring Baltp. Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Tipton - Eline Funeral Home	Hampstead, Md.	FEB 23 1968	J. Charles Yingling

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02438

CERTIFICATE OF DEATH

02424

1. DECEASED-NAME (Type or print) First: CHARLES	Middle: HENRY	Last: BRENT	2a. DATE OF DEATH Month Day Year: FEBURARY 1,1968
			2b. HOUR: 3:10 P M
3. SEX: Male	4. RACE: Negro	5. DATE OF BIRTH: 02-13-1899	6. AGE (In years last birthday): 68 YRS. IF UNDER 1 YEAR: MONTHS, DAYS IF UNDER 24 HRS.: HOURS, MIN.
7a. BIRTHPLACE (State or foreign country): Washington, D.C.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	9. COUNTY OF DEATH: Carroll Md.
10. CITY OR TOWN OF DEATH: Sykesville	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Springfield State Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Clerk	12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland	13b. COUNTY: Baltimore City	13c. CITY OR TOWN: Baltimore	13d. INSIDE CITY LIMITS? YES ☒ NO ☐ — 13e. STREET AND NUMBER: No fixed address
14. FATHER'S NAME First: Charles	Middle	Last: Brent, Sr.	15. MOTHER'S MAIDEN NAME First: Maggie	Middle	Last: Brent
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown): Unk. (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: Unk.	17. INFORMANT Address: Records, Springfield State Hospital	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bilateral bronchopneumonia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Days
485 X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 491 X
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).
CBS assoc. with cerebral arteriosclerosis, with psychotic reaction

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County Stote	

22a. **I certify** that (I) (this hospital) attended the deceased from 2-13-64, 19____, to 2-1-68, 19____, that (I) (we) last saw the deceased alive an 2-1-68 19____, and that in (my) (our) opinion death occurred on the dote and hour and from the causes stated above, (I) (we) (did) (did nat) view the body after death.

22b. SIGNATURE: Agustin del Campo. DEGREE: ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒		22c. DATE SIGNED: 2-2-68
22d. PHYSICIAN'S NAME (Type): Agustin del Campo, M. D.	22e. ADDRESS: Springfield State Hospital Sykesville, Maryland 21784	

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE: Feb 6-68	23c. NAME OF CEMETERY OR CREMATORY: U. of Md. Med. School	23d. LOCATION (City or Town): Baltimore	(County): Md. (State)
24. FUNERAL DIRECTOR: Revell Funeral Home	ADDRESS: Sykesville, Md.	25a. REC'D BY REGISTRAR DATE: FEB 8 1968	25b. REGISTRAR'S SIGNATURE: Charles Judge	

1

FOR STATE HEALTH DEPT.

02433

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02425

1. DECEASED-NAME (Type or Print)	First: ETHEL	Middle: ESTELLA	Last: BROTHERS	2a. DATE KNOWN OF DEATH [X] ESTIMATED [ ]	Month: 2-	Doy: 8-	Year: 1968	2b. HOUR: 1:20 A.M.
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH: OCT. 15, 1891	6. AGE (In years last birthday): 76 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	2c. DATE PRONOUNCED DEAD Month: 2-	Doy: 8-	Year: 1968	2d. HOUR: 1:20 A.M.

7a. BIRTHPLACE (State or foreign country): CARROLL Co. MD.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]	9. COUNTY OF DEATH: CARROLL CO. Md.
10. CITY OR TOWN OF DEATH: WESTMINSTER	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): D.O.A. CARROLL CO. HOSPT.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): NONE	12b. KIND OF BUSINESS OR INDUSTRY: —
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MD.	13b. COUNTY: CARROLL	13c. CITY OR TOWN: WESTMINSTER	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	13e. STREET AND NUMBER: 427 E. MAIN ST.
14. FATHER'S NAME First: EDWARD	Middle: —	Last: TROYER	15. MOTHER'S MAIDEN NAME First: ALICE	Middle: —	Last: SENTZ
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): — (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: —	17. INFORMANT: MR. EDWARD GREEN	ADDRESS: 425 E. GREEN St. WESTMINSTER MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Myocardial Infarction acute	Yrs. Mos.
DUE TO, OR AS A CONSEQUENCE OF (b)	Arteriosclerotic Cardiovascular disease	7-8-yrs
DUE TO, OR AS A CONSEQUENCE OF (c)		

4109

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

4201

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES [ ] NO [ ]
21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY Month, Doy, Yeor HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State

22a. **I certify** that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [ ], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Wyleen Speicher M.D.

EXAMINER'S NAME (Type)

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

ADDRESS (Street, City or Town, or County): 63 E. Main Westminster Carroll

22b. DATE SIGNED: 2-8-68

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)		
BURIAL	2/11/68	MT ZION CEMETERY	NEAR HAMPSTEAD, MD.		
24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE: FEB 13 1968	25b. REGISTRAR'S SIGNATURE		
J. S. Myers Jr.	Westminster, Md.				

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PMS. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health priar to buriol, cremotion, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M REV. 1/68

1

02440

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02426

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 haurs after death.

1. DECEASED-NAME (Type or print) First: GUY	Middle: LEROY	Last: CARTNAIL	2a. DATE OF DEATH Month: FEBRUARY Day: 21 Year: 1968
2b. HOUR: 11:50 A			
3. SEX: Male	4. RACE: Negro	5. DATE OF BIRTH: 06/03/78	6. AGE (In years last birthday): 89 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.		
7a. BIRTHPLACE (State or foreign country): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Carroll Md.
10. CITY OR TOWN OF DEATH: Sykesville	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Springfield State Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Farm worker	12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland	13b. COUNTY: Frederick	13c. CITY OR TOWN: Frederick	13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET AND NUMBER: 388 Catoctin Avenue			
14. FATHER'S NAME First: Thomas Henry	Middle	Last: Cartnail	15. MOTHER'S MAIDEN NAME First: Hester Ellen Middle	Last: Palmer
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown): None	(If yes give war or dates of service): *****	16b. SOCIAL SECURITY NO.: 220-34-6499-A	17. INFORMANT Address: Records, Springfield State Hospital

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Uremia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: days

403 ✕

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) Nephrosclerosis — years

DUE TO, OR AS A CONSEQUENCE OF

(c) General arteriosclerosis — years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

446 ✕

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, natify medicol examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Port 1 or Port 2, Item 18.)	
21d. INJURY OCCURRED While ☐ at work Not while ☐ at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	

22a. **I certify** that (I) (this hospital) attended the deceased from 2/1/68, 19____, to 2/21/68, 19____, that (I) (we) last saw the deceased ~~alive~~ on 2/21/68 19____, and that in (my) (aur) apinian death accurred an the date and haur and from the couses stated above, (I) (we) (did) (did nat) view the bady after death.

22b. SIGNATURE: Octavio A Ruizmd	DEGREE: ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒	22c. DATE SIGNED: 2/21/68	
22d. PHYSICIAN'S NAME (Type): Octavio A. Ruiz, M.D.	22e. ADDRESS: Springfield State Hospital Sykesville, Maryland		
23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 2-24-68	23c. NAME OF CEMETERY OR CREMATORY: Fairview	23d. LOCATION (City or Town) (County) (State): Frederick Frederick Md
24. FUNERAL DIRECTOR ADDRESS: C.E. Hicks, 111 Frederick, Md	25a. REC'D BY REGISTRAR DATE: FEB 26 1968	25b. REGISTRAR'S SIGNATURE: Charles Jordan	

VR A15 (4)
30M REV. 1/68

1

02441

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02427

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
Worley	McKinley	Cheeks	2	7	68	5 45 AM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.
Male	Caucasian	3/22/97	70 YRS.	10			

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
Va.	U.S.A.		Carroll Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Union Bridge	Bucher John Rd	Farmer	OWN FARM

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☐ NO ☑	13e. STREET AND NUMBER
Maryland	Carroll	Union Bridge		Bucher John Road

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Floyd	Wesley	Cheeks	Fannie	(UNKNOWN)	

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
No	215-34-6904A	Pearl Cheeks	Union Bridge, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Metastatic Carcinoma	—
DUE TO, OR AS A CONSEQUENCE OF (b)	Primary Carcinoma prostate gland.	2 yrs. +
DUE TO, OR AS A CONSEQUENCE OF (c)		

185 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

177 X

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☑	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol exominer)	21b. TIME OF INJURY HOUR A.M. P.M. Month Doy Yeor 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While ☐ at work Not while ☐ at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I **certify** that (I) (this hospital) attended the deceased from Jan, 19 66, to 2/7, 19 68, that (I) (we) last saw the deceased alive on 2/7 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Sherrill C. Cheeks	M.D.	☑	☐	☐	2/7/68

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Sherrill C. Cheeks M.D.	Westminster Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	2/10/68	PIPE CREEK	NEW WINDSOR RURAL MD

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
D.D. Hartzler & Sons Union Bridge	FEB 13 1968	Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02442

CERTIFICATE OF DEATH

02428

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
JOHN	FRANCIS	COOK	February 25, 1968	8:05pm

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
Male	White	1/21/92	76 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH
Washington, D.C.	U.S.A.		Carroll Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Sykesville	Springfield State Hospital	Salesman (retired)	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Montgomery	Bethesda	YES [X] NO [ ]	4900 Battery Lane, Apt. 208

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Jesse		Cook	Cecelia		(unk)

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
None	599-05-3516	Records, Springfield State Hospital

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) bilateral bronchopneumonia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: days

485X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 491X

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

CBS, associated with senile brain disease with psychotic reaction.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES [X] NO [ ]	Yes

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I **certify** that (I) (this hospital) attended the deceased from 10/9/67, 19____, to 2/25/68, 19____, that (I) (we) last saw the deceased alive on 2/25/68 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE: ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS. [X]	22c. DATE SIGNED
Octavio A Ruiz		2/26/68

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Octavio A. Ruiz, M.D.	Springfield State Hospital Sykesville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Cremation	2/27/68	Cedar Hill Crematory	Suitland Pr. Geo Md

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Robert A Pumphrey 7557 Wisc. Ave Bethesda Md	FEB 29 1968	Charles Jenkins

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02443 02429

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First: BOYD	Middle: -	Last: CRITES	2a. DATE OF DEATH: For Month 12 Day 1968 Year
2b. HOUR: 3:25 PM			
3. SEX: M	4. RACE: W	5. DATE OF BIRTH: 5-18-1882	6. AGE (In years last birthday): 85 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN
7a. BIRTHPLACE (State or foreign country): MOOREFIELD, W. VA	7b. CITIZEN OF WHAT COUNTRY?: U. S. A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐	9. COUNTY OF DEATH: CARROL Md.
10. CITY OR TOWN OF DEATH: WESTMINSTER,	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): CARROL Co. Gen. Hosp.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): LABORER	12b. KIND OF BUSINESS OR INDUSTRY: FARM.
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MD	13b. CDUNTY: CARROLL	13c. CITY OR TOWN: MANCHESTER	13d. INSIDE CITY LIMITS? YES ☑ NO ☐
13e. STREET AND NUMBER: 11 CHURCH ST			
14. FATHER'S NAME First: JACOB	Middle:	Last: CRITES.	15. MDTHER'S MAIDEN NAME First:	Middle:	Last:
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown): NO (If yes give war or dates of service)	16b. SDCIAL SECURITY ND.: 170-24-1717	17. INFDRMANT: MRS. MARGARET SWARTZ Address: EAST BELINDA ST	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Metastatic Carcinoma
185 X
Conditions, if ony, which gove rise to immediote couse (a), stating the underlying couse last.
DUE TO, OR AS A CONSEQUENCE OF (b): Carcinoma of the prostate
DUE TO, OR AS A CONSEQUENCE OF (c):
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIDNS CONTRIBUTING TD DEATH BUT NDT RELATED TD THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
177 X

19a. DATE DF DPERATION	19b. CDNDITIDN FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☑	20b. IF YES, WERE FINDINGS CDNSIDERED IN CERTIFYING CAUSES DF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, natify medical exominer)	21b. TIME DF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HDW INJURY DCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)	
21d. INJURY OCCURRED While ☐ at work Nat while ☐ at work	21e. PLACE DF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I **certify** that (I) (this haspital) attended the deceased from Feb 4, 1968, to Feb 12, 1968, that (I) (we) last saw the deceased alive an Feb 12, 1968, and that in (my) (aur) apinian death accurred an the date and haur and fram the causes stated abave, (I) (we) (did) (did not) view the bady after death.

22b. SIGNATURE: John S. Harshey, M.D. DEGREE	ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐	22c. DATE SIGNED: 2/12/68	
22d. PHYSICIAN'S NAME (Type): JOHN S. HARSHEY M.D.	22e. ADDRESS: 8 Landon St. Westminster, Md		
23a. BURIAL, CREMATIDN, REMDVAL (Specify): Burial	23b. DATE: 2-15-1968	23c. NAME OF CEMETERY DR CREMATORY: Rest Haven Cemetery	23d. LOCATION (City or Town): Hanover (County): York Co (State): Pa
24. FUNERAL DIRECTDR: Tipton-Cline	ADDRESS: Hampstead, Md.	25a. REC'D BY REGISTRAR DATE: FEB 15 1968	25b. REGISTRAR'S SIGNATURE:

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02445 — 02430

1. DECEASED-NAME (Type or print): First EIMER Middle E Last CROASDALE
2a. DATE OF DEATH: Month Feb Day 1 Year 1968
2b. HOUR: 11:50 PM
3. SEX: MALE
4. RACE: WHITE
5. DATE OF BIRTH: October 11 1879
6. AGE (In years last birthday): 88 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS.: HOURS MIN.
7a. BIRTHPLACE (State or foreign country): Phila Penna
7b. CITIZEN OF WHAT COUNTRY? USA
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. COUNTY OF DEATH: Carroll Md.
10. CITY OR TOWN OF DEATH: Manchester Md
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Longview Nursing Home
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Foreman
12b. KIND OF BUSINESS OR INDUSTRY: Food Processing
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland
13b. COUNTY: Harford
13c. CITY OR TOWN: Bel Air
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET AND NUMBER: 100 West Belcrest
14. FATHER'S NAME First Collins Middle C Last CROASDALE
15. MOTHER'S MAIDEN NAME First ANNIE Middle Lost TITUS
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: No (If yes give war or dates of service)
16b. SOCIAL SECURITY NO.: 184-01-4331
17. INFORMANT: EMMETT CROASDALE Address: Bel Air Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Vascular Hemmorage
DUE TO, OR AS A CONSEQUENCE OF (b): Arteriosclerotic Cardio Vascular Disease
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4129
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4221

19a. DATE OF OPERATION: —
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: —
20a. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? —
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While ☐ at work Not while ☐ at work
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from June 16, 1967, to Feb 1, 1968, that (I) (we) last saw the deceased alive on January 31 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Joseph E. Bush DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22c. DATE SIGNED
22d. PHYSICIAN'S NAME (Type): Joseph E. Bush M.D.
22e. ADDRESS: Hampstead Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: Feb. 5, 1968
23c. NAME OF CEMETERY OR CREMATORY: Highland Cemetery
23d. LOCATION (City or Town) (County) (State): Hopewell Mercer N.J.
24. FUNERAL DIRECTOR: John E. Hoff ADDRESS: Hampstead Md.
25a. REC'D BY REGISTRAR DATE: FEB 5 1968
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02445 02431

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
William	A.	Davidson	Feb.	21,	1968	1 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 1 YEAR DAYS	IF UNDER 24 HRS. HOURS	IF UNDER 24 HRS. MIN
Male	White	Nov. 7, 1875	92 YRS.				

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
Carroll Co. Md.	U.S.A.	WIDOWED [X]	Carroll Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Hampstead	229 N. Main St.	Construction	Builder

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Md.	Carroll	Hampstead	YES [X] NO [ ]	229 N. Main St.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
William	A.	Davidson Sr.	Susanna	D.	Hoffman

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
NO	579-12-4592A	Mrs. W. Earl Davidson	N. Main St. Hampstead

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Chronic Myocarditis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cardio Vascular

DUE TO, OR AS A CONSEQUENCE OF (c) Disease

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [X]	

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from 3/3/61, 19____, to 2/21/68, 19____, that (I) (we) last saw the deceased alive on 2/20/68 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Joseph E. Bush	MD	[X]	[ ]	[ ]	2-21-68

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Joseph E. Bush MD	Hampstead Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Feb. 24, 1968	Carrollton Cemetery	Finksburg Carroll Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Tipton - Eline Funeral Home	Hampstead, Md.	FEB 26 1968	Charles Jones

VR A15 (4)
30M REV. 1/68

1

02446

Daisy

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02432

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First: Daisy	Middle: I	Last: Dintaman.	2a. DATE OF DEATH: Month 2 Day 6 Year 68
2b. HOUR: 12:30 P M			
3. SEX: Female	4. RACE: white	5. DATE OF BIRTH: Sept 21, 1887	6. AGE (In years last birthday): 80 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.		
7a. BIRTHPLACE (State or foreign country): Lentsville, VA	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: Carroll Md.
10. CITY OR TOWN OF DEATH: manchester md	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 128 N Main ST. Longview nursing Home	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife	12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.	13b. COUNTY: Carroll	13c. CITY OR TOWN: Uniontown	13d. INSIDE CITY LIMITS? YES ☐ NO ☐
13e. STREET AND NUMBER: Rural Box 25			
14. FATHER'S NAME First: William	Middle:	Last: Shumacher	15. MOTHER'S MAIDEN NAME First: Christine	Middle:	Last: Speaks.
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown): No. (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 212-03-3354	17. INFORMANT: Ruth Rueker (daughter)	Address: Uniontown, md. Box 25

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Myocardial Infarction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 10 days

4109

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Arteriosclerotic Cardio Vascular — 2 yrs

DUE TO, OR AS A CONSEQUENCE OF (c): Severe

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

4201

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☑	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from 1/27, 1968, to 2/6, 1968, that (I) (we) last saw the deceased alive on 2/5, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.

22b. SIGNATURE: W H Foard MD	DEGREE	ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐	22c. DATE SIGNED: 2/6/68
22d. PHYSICIAN'S NAME (Type): W.H Foard MD		22e. ADDRESS: Manchester, Md 21102	

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 2/9/68	23c. NAME OF CEMETERY OR CREMATORY: Union Cemetery	23d. LOCATION (City or Town): Lovettsville	(County) (State): Va.
24. FUNERAL DIRECTOR: Feete Funeral Home	ADDRESS: Brunswick, Md.	25a. REC'D BY REGISTRAR DATE: FEB 8 1968	25b. REGISTRAR'S SIGNATURE: J. Charles Judge	

VR A15 (4)
30M REV. 1/68

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

02447

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02433

1. DECEASED-NAME (Type or print) First: MILLARD	Middle:	Last: DOUGHERTY	2a. DATE OF DEATH Month: 2 Day: 22 Year: 68
2b. HOUR: P 3:30 M			

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
Male	Caucasian	05/05/83	84 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
Maryland	U.S.A.		Carroll Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during mast af working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Sykesville	Springfield State Hosp.	none	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	---	Balto.	YES ☐ NO ☐	25 S. Linwood Ave.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
George	W	Dougherty	Georgiana		Dunn

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
no	218-54-4481	Hospital records

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Pulmonary Infarction CHF — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF (b) Pulmonary Embolism

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 4129 4227

DUE TO, OR AS A CONSEQUENCE OF (c) ASCVD

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Schizophrenic reaction, catatonic type

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, natify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Manth Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Nat while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** thot ☒ (this hospitol) attended the deceosed from 5/15, 1924, to 2/22, 1968, thot ☒ (we) lost sow the deceosed olive on 2/22 1968, and thot in ☒ (our) opinion deoth occurred on the dote and hour and from the couses stoted obove, ☒ (we) (did) (did not) view the body ofter deoth.

22b. SIGNATURE	DEGREE	ATTENDING PHYS. ☐	MED. DIRECTOR ☐	STAFF PHYS. ☐	22c. DATE SIGNED
Gracito V. Patricio M.D.					2/22/68.

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
GRACITO V. PATRICIO M.D.	Springfield State Hospital, Sykesv., Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town)	(County)	(State)
Burial	2-26-68	Freedom Cemetery	Sykesville		Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Harry W. Haight	Sykesville, Md.	FEB 29 1968	Charles Jones

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items 2,4,5,6,9,10, & 11 Film G39A 2/28/68 kk

CERTIFICATE OF DEATH

02434

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
Estelle	P.	Edson	2	13	68	2:35 A.M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN
Female	W	6/26/88	79 YRS.				

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
			Carroll Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Westminster	Carroll County General		

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET AND NUMBER

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) myocardial Infarction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: mins
410.9
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4301
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Pelvic abscess - Intestinal obstruction - Dehydration - Probable septicemia

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
2/11/68	Intestinal obstruction + Pelvic abscess	YES ☐ NO ☑	

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) ~~(this hospital)~~ attended the deceased from 2/10, 19 68, to 2/13, 19 68, that (I) ~~(we)~~ last saw the deceased alive on 2/13 19 68, and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above, (I) ~~(we)~~ (did) ~~(did not)~~ view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS. ☑	MED. DIRECTOR ☐	STAFF PHYS. ☐	22c. DATE SIGNED
Robert F. Bell, M.D.					2/13/68

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Removal	Feb. 14, 1968	Mt. Moriah Cemetery Burial	BALTIMORE, MD.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Harold Funeral Home	Pikesville, Md.	FEB 16 1968	Charles Yeager

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removol, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02449

CERTIFICATE OF DEATH

02435

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
JOSEPHINE	(NMN)	EDWARDS	FEBRUARY 26, 1968	5:00 P M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
Female	White	3-[illegible]/5/88.	[illegible] 79 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
New York	U.S.A.		Carroll Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Sykesville	Springfield State Hospital	Housewife	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Baltimore City	Baltimore	YES ☒ NO ☐	5923 Eurith Ave.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Frank		Grammick	Catherine		Schubert

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
No	----	Records, Springfield State Hospital

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease — Approximate interval between onset and death: Years

4129

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Generalized arteriosclerosis — Years

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

CBS assoc.with cerebral arteriosclerosis, with psychotic reaction

4221

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from 12-6-58, 19___, to 2-26-68, 19___, that (I) (we) last saw the deceased alive on 2-26-68 19___, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Agustin del Campo M.D.		☐	☐	☒	2-27-68

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Agustin del Campo, M. D.	Springfield State Hospital Sykesville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	3/1/68.	Woodlawn Cemetery	Baltimore, Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Leonard J. Ruck, Inc. Balto. Md. 21214	FEB 29 1968	Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02450 02436

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

1. DECEASED-NAME (Type or print) First / Middle / Last	MYRTLE JANE ELLIOT	2a. DATE OF DEATH Month / Day / Year	2 / 20 / 68
2b. HOUR	6.40 P.M.		
3. SEX	FEMALE		
4. RACE	WHITE		
5. DATE OF BIRTH	SEPT. 25, 1894		
6. AGE (In years last birthday)	73 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (State or foreign country)	LISBON, N.Y	7b. CITIZEN OF WHAT COUNTRY?	U.S.A.
8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	WIDOWED ☑	9. COUNTY OF DEATH	CARROLL Md.
10. CITY OR TOWN OF DEATH	WESTMINSTER	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	CARROLL Co. GEN. HOSP.
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	HOUSE-WIFE	12b. KIND OF BUSINESS OR INDUSTRY	—
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	NEW YORK	13b. COUNTY	ONONDAGA
13c. CITY OR TOWN	SYRACUSE	13d. INSIDE CITY LIMITS? YES / NO	YES ☑ NO ☐
13e. STREET AND NUMBER	213 LINCOLN AVE.		
14. FATHER'S NAME First / Middle / Last	NATHANIEL JAMES ROBINSON	15. MOTHER'S MAIDEN NAME First / Middle / Last	? KNUDTSON
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)	—	(If yes give war or dates of service)	—
16b. SOCIAL SECURITY NO.	134-12-6244A	17. INFORMANT	JAMES F. ELLIOT
Address	226 LIBERTY ST. WESTMINSTER, MD		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 24 HOURS

DUE TO, OR AS A CONSEQUENCE OF

(b) ARTERIOSCLEROTIC HEART DISEASE — YEARS

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate couse (a), stating the underlying cause last. 4109

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

4201

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. **I certify** that (I) (this hospital) attended the deceased from 2/15, 1968, to 2/20, 1968, that (I) (we) last saw the deceased alive on 2/20 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	Vincent J. Riccio Jr.	DEGREE: ATTENDING PHYS. ☑ / MED. DIRECTOR ☐ / STAFF PHYS. ☐	22c. DATE SIGNED 2/20/68
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS	

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 2/22/68	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town)	(County) (State)
Burial		EVERGREEN MEMORIAL GARDENS	FINKSBURG, MD.	
24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	FEB 26 1968	25b. REGISTRAR'S SIGNATURE
E. E. Myers Jr.	Westminster, Md.			

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02451 02437

1. DECEASED-NAME (Type or print): First ARTHUR Middle AUGUSTUS Last FRITZ
2a. DATE OF DEATH: Month FEB. Day 19 Year 1968
2b. HOUR: 9 P.M.
3. SEX: MALE
4. RACE: WHITE
5. DATE OF BIRTH: 3/5/1906
6. AGE (In years last birthday): 61 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN
7a. BIRTHPLACE (State or foreign country): MARYLAND
7b. CITIZEN OF WHAT COUNTRY?: U.S.
8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
9. COUNTY OF DEATH: CARROLL COUNTY Md.
10. CITY OR TOWN OF DEATH: NEW WINDSOR
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): HORTON BOARDING HOME
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): LABORER
12b. KIND OF BUSINESS OR INDUSTRY: FARM
13a. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE: MARYLAND
13b. COUNTY: CARROLL
13c. CITY OR TOWN: NEW WINDSOR
13d. INSIDE CITY LIMITS? YES ☐ NO ☒
13e. STREET AND NUMBER: RURAL
14. FATHER'S NAME First THOMAS Middle Last FRITZ
15. MOTHER'S MAIDEN NAME First BETTY Middle Last SHANE
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16b. SOCIAL SECURITY NO.: 213-01-1316
17. INFORMANT: THOMAS FRITZ SR. Address: LINWOOD MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): arteriosclerotic C.V.D. — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: years
4129
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4221

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☐
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter noture of injury in Part I or Part 2, Item 18.)
21d. INJURY OCCURRED While at work ☐ Not while at work ☐
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County Stote

22a. I certify that (I) (this hospital) attended the deceased from Apr., 19 67, to 2/19, 19 68, that (I) (we) last saw the deceased alive an 2/19 19 68, and that in (my) ~~(our)~~ apinian death accurred an the date and haur and from the causes stated abave, (I) (we) (did) ~~(did not)~~ view the bady after death.

22b. SIGNATURE: M.E. Robertson MD DEGREE — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22c. DATE SIGNED: 2/20/68
22d. PHYSICIAN'S NAME (Type): M.E. ROBERTSON
22e. ADDRESS: NEW WINDSOR MD

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE: 2/22/68
23c. NAME OF CEMETERY OR CREMATORY: COUNTY HOME CEM
23d. LOCATION (City or Town) (County) (Stote): WESTMINSTER MD
24. FUNERAL DIRECTOR: D.O. Hartle & Sons ADDRESS: NEW WINDSOR MD
25a. REC'D BY REGISTRAR DATE: FEB 23 1968
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

1

02452

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02438

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
Robert	E.	Greenshields	Feb	25	1968	3:55 A M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
Male	White	June 28, 1899	68 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
Mich.	U.S.A.		Carroll Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Westminster	Carroll Co. Hospital	Engineer	State

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET AND NUMBER
Md.	Carroll	Sykesville		Carroll Highlands Rd.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
John	A.	Greenshields	Della	-	Hubbard

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
No		Florence Greenshields	Sykesville, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Pulmonary edema	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b)	Coronary thrombosis	
DUE TO, OR AS A CONSEQUENCE OF (c)	Atherosclerotic Heart Disease	7 yrs

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

4201

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from Feb 23, 19 68, to Feb 25, 19 68, that (I) (we) last saw the deceased alive on Feb 25 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
John S. Harshey	MD	☒	☐	☐	2/25/68

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
JOHN S. HARSHEY MD	Sandosa St. Westminster Md

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town)	(County)	(State)
Burial	2-28-68	Lake View Memorial	Sykesville		Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Harry W. Haight	Sykesville, Md.	FEB 29 1968	

VR A15 (4)
30M REV. 1/68

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02453 02439

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
ARTHUR	PHILIP	HOFFA	FEBRUARY 27, 1968	9:55 A M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
Male	White	10-8-1880	87 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
Pennsylvania	U.S.A.		Carroll Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Sykesville	Springfield State Hospital	Miner/farmer (retired)	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Allegany	Barton	YES ☒ NO ☐	None

14. FATHER'S NAME First Middle Last	15. MOTHER'S MAIDEN NAME First Middle Last
~~Unk.~~ John Hoffa	Margaret ~~Unk.~~ Umhultz

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
No	220-07-3380	Records, Springfield State Hospital

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Uremia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Days

250.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Diabetic acidosis — Days

DUE TO, OR AS A CONSEQUENCE OF (c) Diabetic mellitus — Years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

260 X

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Port 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I **certify** that (I) (this hospital) attended the deceased from 2-23-68, 19____, to 2-27-68, 19____, that (I) (we) last saw the deceased alive an 2-27-68 19____, and that in (my) (aur) apinian death accurred an the date and haur and from the causes stated abave, (I) (we) (did) (did nat) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Octavio A Ruiz M.D.		☐	☐	☒	2-27-68

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Octavio A. Ruiz, M. D.	Springfield State Hospital Sykesville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	3/2/68	Philos	Westernport Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
E L Boal	Westernport, Md.	FEB 29 1968	Charles Suggs

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02454 02440

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print): First ANNIE Middle MISSOURI Last HOSFELD
2a. DATE OF DEATH: Month FEB. Day 1 Year 68
2b. HOUR: 6:10 P.M.
3. SEX: FEMALE
4. RACE: WHITE
5. DATE OF BIRTH: DEC. 16 1873
6. AGE (In years last birthday): 94 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.
7a. BIRTHPLACE (State or foreign country): CARROLL Co. MD. U.S.A.
7b. CITIZEN OF WHAT COUNTRY?
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
9. COUNTY OF DEATH: CARROLL CO. Md.
10. CITY OR TOWN OF DEATH: WESTMINSTER
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): 35 W. MAIN ST.
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): HOUSE-WIFE
12b. KIND OF BUSINESS OR INDUSTRY: U.S.A.
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND
13b. COUNTY: CARROLL
13c. CITY OR TOWN: WESTMINSTER
13d. INSIDE CITY LIMITS? YES ☑ NO ☐
13e. STREET AND NUMBER: 35 W. MAIN ST.
14. FATHER'S NAME First JACOB Middle Last ESSICH
15. MOTHER'S MAIDEN NAME First SUSANNA Middle M. Last BAUMGARDNER
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)
16b. SOCIAL SECURITY NO.
17. INFORMANT: MRS. RAYMOND L. BENSON, Address SAME ADDRESS

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Cardiac Failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3-4 hrs
401X
DUE TO, OR AS A CONSEQUENCE OF
(b) Arteriosclerosis & General Hypertension, 4 years — 24 hrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c) Respiratory Infection

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
444 X

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ DR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)
21d. INJURY OCCURRED While at work ☐ Not while at work ☐
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County Stote

22a. **I certify** that (I) (this hospital) attended the deceased from 4-16, 1963, to 2/1/68, 1968, that (I) (we) last saw the deceased alive on 2-1-68 1968, and that in (my) (aur) apinian death accurred an the date and haur and fram the causes stated abave, (I) (we) (did) (did nat) view the bady after death.

22b. SIGNATURE, DEGREE: Wyleen Speicher — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22c. DATE SIGNED: 2-2-68
22d. PHYSICIAN'S NAME (Type)
22e. ADDRESS: Westminster md

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE: 2/ /68
23c. NAME OF CEMETERY OR CREMATORY: KRIDERS CEMETERY
23d. LOCATION (City or Town) (County) (Stote): RORAL, WESTMINSTER MD
24. FUNERAL DIRECTOR: J. S. Myers, Jr. ADDRESS: Westminster, Md.
25a. RECD BY REGISTRAR DATE: FEB 5 1968
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4) 30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02455 02441

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: Leona	Middle: - -	Last: Hudnet	2a. DATE OF DEATH Month: 2 Day: 2 Year: 68	2b. HOUR: 1:30 PM
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH: 11-9-13	6. AGE (In years last birthday) YRS.: 54	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
				2 / 23	13 / 30
7a. BIRTHPLACE (State or foreign country): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Carroll County, Md.		
10. CITY OR TOWN OF DEATH: Sykesville	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): Springfield State Hosp.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): housekeeping	12b. KIND OF BUSINESS OR INDUSTRY: none		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.	13b. COUNTY: Baltimore	13c. CITY OR TOWN: Dundalk	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET AND NUMBER: RFD, Box 439	
14. FATHER'S NAME First: William	Middle: H.	Last: Hudnet	15. MOTHER'S MAIDEN NAME First: Ella	Middle: unk.	Last: McLaughlin
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: no	(If yes give wor or dates of service)	16b. SOCIAL SECURITY NO.: 216-05-7033	17. INFORMANT: Records, Springfield St. Hospital, Sykes.	Address	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Coronary Heart Disease — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1½ hours

410.9

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last. 420.1

DUE TO, OR AS A CONSEQUENCE OF (b): Arteriosclerosis — years

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Epileptic psychosis

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol exominer)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County Stote	

22a. **I certify** that (I) (this haspital) attended the deceased from 2-20-33, 1933, to 2-2-, 1968, that (I) (we) lost saw the deceased olive an February 2, 1968, and thot in (my) (our) opinian death occurred on the date and haur and from the causes stated above, (I) (we) (did) (did not) view the body ofter death.

22b. SIGNATURE: Mario C. Comas M.D. DEGREE	ATTENDING PHYS. ☐	MED. DIRECTOR ☐	STAFF PHYS. ☒
22c. DATE SIGNED: 2-2-68			
22d. PHYSICIAN'S NAME (Type): Mario Comas, M.D.	22e. ADDRESS: Springfield State Hospital Sykesville, Maryland		

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL	23b. DATE: 2/5/68	23c. NAME OF CEMETERY OR CREMATORY: OAK LAWN	23d. LOCATION (City or Town): BALTO.	(County): MD (State):
24. FUNERAL DIRECTOR: J. G. CONNELLY SONS	ADDRESS: 300 MACE	25a. REC'D BY REGISTRAR DATE: FEB 6 1968	25b. REGISTRAR'S SIGNATURE: J. Charles Judge	

VR A15 (4) 30M REV. 1/68

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02456 02442

1. DECEASED-NAME (Type or Print) First: LEMUEL	Middle: G.	Last: KELBAUGH	2a. DATE KNOWN OF DEATH ESTIMATED ☐ Month Day Year: Feb. 9, 1968	2b. HOUR: 6:20 A M		
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: March 13, 1877	6. AGE (In years last birthday): 90 YRS. IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.	2c. DATE PRONOUNCED DEAD Month Feb. Day 9, Year 19	2d. HOUR: 6:20 A M	
7a. BIRTHPLACE (State or foreign country): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: Carroll Md.			
10. CITY OR TOWN OF DEATH: Woodbine	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): R.D.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Retired B.& O. R.R.	12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland	13b. COUNTY: Carroll	13c. CITY OR TOWN: Woodbine	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET AND NUMBER: R.D.		
14. FATHER'S NAME First: John	Middle	Last: Kelbaugh	15. MOTHER'S MAIDEN NAME First: Louisa	Middle	Last: Shipley	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): ? (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 705-05-7445	17. INFORMANT: Mrs. Eleanor Kelbaugh	ADDRESS: Box 661, Severna Park, Md.			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Smoke to Soot Inhalation — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

890X

Conditions, if any, which gove rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b): Incidental to Conflagration

DUE TO, OR AS A CONSEQUENCE OF

(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

9160 Arteriosclerotic Cardiovascular Disease

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☒ NO ☐
21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M.: 5:15 ~~XX~~ Feb. 9, 19 68	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.): Apparently started from kerosene heater
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.): Home	21f. LOCATION Street or R.F.D. No.: Rd. Woodhine Ashleys Trailer Park; City or Town: Carroll; County: Md; State

22a. **I certify** that I took charge of the remains described above, held on Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐ Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐
ADDRESS(Street, city, town, or county)

22b. DATE SIGNED: 2-9-68

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 2/10/1968	23c. NAME OF CEMETERY OR CREMATORY: Ebenezer Cemetery	23d. LOCATION (City or Town) (County) (State): Carroll Co., Md.	
24. FUNERAL DIRECTOR: C. M. Waltz	ADDRESS: Box 241, Sykesville, Md.	25a. REC'D BY REGISTRAR DATE: FEB 13 1968	25b. REGISTRAR'S SIGNATURE	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02457 — 02443

1. DECEASED-NAME (Type or print): First: Howard — Middle: T — Last: Kemp.
2a. DATE OF DEATH: Month: Feb. — Day: 8 — Year: 68
2b. HOUR: 3P. M
3. SEX: male
4. RACE: white
5. DATE OF BIRTH: Jan 24, 1886
6. AGE (In years last birthday): 82 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (State or foreign country): Balto. Co. on farm.
7b. CITIZEN OF WHAT COUNTRY?: USA.
8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
9. COUNTY OF DEATH: Carroll. Md.
10. CITY OR TOWN OF DEATH: manchester md.
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 128 N. Main ST. Longview Nursing Home
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
12b. KIND OF BUSINESS OR INDUSTRY: Farmer.
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: md.
13b. COUNTY: Carrol.
13c. CITY OR TOWN: Hampstead
13d. INSIDE CITY LIMITS? YES ☐ NO ☑
13e. STREET AND NUMBER: Fairmount Rd. RFD #2
14. FATHER'S NAME: First: William — Middle — Last: Kemp
15. MOTHER'S MAIDEN NAME: First — Middle: Kathryn — Last: Hardenbrook
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16b. SOCIAL SECURITY NO.: 215-14-1400A
17. INFORMANT: Leslie Kemp. wife. Address: Fairmount Rd. Hampstead Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of Lung — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 12mo
DUE TO, OR AS A CONSEQUENCE OF
(b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
163X Diabetes Mellitus.

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☑
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY: HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work ☐ Not while at work ☐
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from Jan. 19 67, to Feb. 8, 19 68, that (I) (we) last saw the deceased alive on Feb. 8 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Maurice C. Porterfield — DEGREE: ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22c. DATE SIGNED: 2-8-68
22d. PHYSICIAN'S NAME (Type)
22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: Feb. 10, 1968
23c. NAME OF CEMETERY OR CREMATORY: Greenmount Cemetery
23d. LOCATION (City or Town) (County) (State): Greenmount Carroll Co. Md.
24. FUNERAL DIRECTOR — ADDRESS: Tipton - Eline Funeral Home Hampstead, Md.
25a. REC'D BY REGISTRAR DATE: FEB 14 1968
25b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02459 02444

1

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
Sadie	Gertrude	Klein	2 - 4 - 68	1:45 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
female	white	7/24/96	71 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
Maryland	USA	WIDOWED [X]	Carroll Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Rural--Sykesville	Springfield State Hospital	housewife	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Md.	—	Baltimore	YES [X] NO [ ]	2005 Crestview Road

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
William	Joseph	Hinkle	Jennie	Gertrude	Reinhart

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
no	none known	Mrs James R Buerts Springfield Hospital records	Same Sykesville, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Abscess of left upper lobe of lung.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 437.9 334.x
DUE TO, OR AS A CONSEQUENCE OF (b) Suppurative confluent bronchopneumonia.
DUE TO, OR AS A CONSEQUENCE OF (c) Diverticulosis. Generalized arteriosclerosis. Emaciation.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Chronic brain syndrome with cerebral arteriosclerosis with psychotic reaction.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (X) (this haspital) attended the deceased from 9/4/ , 1963 , ta 2/4/68 , 19 , that (X) (we) last saw the deceased alive an 2/4/68 19 , and thot in (X) (our) apinion deoth occurred on the dote ond hour ond from the causes stoted above, (X) (we) (did) (did not) view the bady ofter deoth.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Ramon P. Lopez, M.D.		[ ]	[ ]	[X]	2/4/68

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Ramon P. Lopez, M.D.	Springfield State Hospital Sykesville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	2/7/68	Loudon Park	Baltimore, Maryland

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Leonard J Ruck Inc Baltimore, Md	FEB 5 1968	Charles Jung

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, ar removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02459

CERTIFICATE OF DEATH

02445

1. DECEASED-NAME (Type or print) First	Middle	Lost	2o. DATE OF DEATH Month Doy Yeor	2b. HOUR
JOSEPH	T.	KUHN	FEBRUARY 5, 1968	5:40 P M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN
Male	White	~~3-5-22~~ 3/19/22	45 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
Maryland	U.S.A.		Carroll Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12o. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Sykesville	Springfield State Hospital	Student	

13o. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Baltimore City	Baltimore	YES ☒ NO ☐	811 Belgian Ave.

14. FATHER'S NAME First	Middle	Lost	15. MOTHER'S MAIDEN NAME First	Middle	Lost
Joseph	A.	Kuhn	Matilda		Athman

16o. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
No	Unk.	Records, Springfield State Hospital

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (o), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (o)	Bilateral bronchopneumonia	Days
DUE TO, OR AS A CONSEQUENCE OF (b)		
Conditions, if any, which gave rise to immediote couse (o), stating the underlying couse lost. 485 X 491 X — DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)
Schizophremic reaction, catatonic type. Diabetic coma

19o. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20o. AUTOPSY? YES ☒ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21o. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Doy Yeor 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	Stote

22a. **I certify** that (I) (this haspital) attended the deceased from 10-25-40, 19____, to 2-5-68, 19____, that (I) (we) last saw the deceased alive an 2-5-68 19____, and that in (my) (aur) apinian death accurred an the date and haur and from the causes stated abave, (I) (we) (did) (did nat) view the bady after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS. ☐	MED. DIRECTOR ☐	STAFF PHYS. ☒	22c. DATE SIGNED
Octavio A Ruiz					2-6-68

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Octavio A. Ruiz, M. D.	Springfield State Hospital Sykesville, Maryland

23o. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (Stote)
Burial	2/8/68	Most Holy Redeemer	Baltimore, Md.

24. FUNERAL DIRECTOR ADDRESS	25o. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Wm. Cook-Brooks West Inc balt. Md. 21228	FEB 9 1968	Charles Yingling

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires thot the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physicion.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02460 02446

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First: ALICE	Middle: ANN	Last: LEPPO	2a. DATE OF DEATH Month: FEB Day: 19 Year: 1968	2b. HOUR: 8 22 P M
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH: AUG. 22, 1892	6. AGE (In years last birthday): 75 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (State or foreign country): CARROLL CO. MD.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: CARROLL Md.	
10. CITY OR TOWN OF DEATH: WESTMINSTER	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): CARROLL CO. GEN. HOSP.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): HOUSE-WIFE	12b. KIND OF BUSINESS OR INDUSTRY: —	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND	13b. COUNTY: CARROLL	13c. CITY OR TOWN: FINKSBURG	13d. INSIDE CITY LIMITS? YES ☐ NO ☑	13e. STREET AND NUMBER: BETHEL ROAD
14. FATHER'S NAME First: NOAH	Middle: W.	Lost: ARBAUGH	15. MOTHER'S MAIDEN NAME First: SARAH	Middle: R.	Last: FLATER
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: — (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 217-12-2599	17. INFORMANT: MR CLARENCE A. LEPPO	Address: SAME	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 24 hours
DUE TO, OR AS A CONSEQUENCE OF (b): Atherosclerotic Heart Disease
DUE TO, OR AS A CONSEQUENCE OF (c): —
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 410.9

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4201

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☑ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County Stote	

22a. **I certify** that (I) (this haspital) attended the deceased from Feb 19, 1968, to Feb 19, 1968, that (I) (we) last saw the deceased alive on Feb 19, 1968, and thot in (my) (our) opinion deoth occurred on the dote ond hour and from the couses stated above, (I) (~~we~~) (did) (~~did not~~) view the body after deoth.

22b. SIGNATURE: John S. Harshey, M.D.	DEGREE: ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐	22c. DATE SIGNED: 2/19/68	
22d. PHYSICIAN'S NAME (Type): JOHN S. HARSHEY M.D.	22e. ADDRESS: 9 Church St. Westminster, Md		

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL	23b. DATE: 2/22/68	23c. NAME OF CEMETERY OR CREMATORY: CARROLLTON CHURCH	23d. LOCATION (City or Town): FINKSBURG	(County): (State): MD
24. FUNERAL DIRECTOR: J. E. Myers, Jr., Westminster, Md	ADDRESS	25a. REC'D BY REGISTRAR DATE: FEB 23 1968	25b. REGISTRAR'S SIGNATURE: Edwin L. Jones	

VR A15 (4)
30M REV. 1/68

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02461 02447

1. DECEASED-NAME (Type or print) First: VIOLA Middle: LUCRETIA Last: LEPPO	2a. DATE OF DEATH Month: Feb 14 Day: 1968 Year	2b. HOUR 12 10 P M	
3. SEX: F	4. RACE: W	5. DATE OF BIRTH: DEC. 8, 1893	6. AGE (In years last birthday): 74 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (State or foreign country): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: CARROLL COUNTY Md.
10. CITY OR TOWN OF DEATH: WESTMINSTER	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): CARROLL CO. GEN. HOSP.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY: HOME
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND	13b. COUNTY: CARROLL	13c. CITY OR TOWN: WESTMINSTER	13d. INSIDE CITY LIMITS? YES ☒ NO ☐ — 13e. STREET AND NUMBER: 24 PENNSYLVANIA AVE.
14. FATHER'S NAME First: WILLIAM Middle: R. Last: YINGLING	15. MOTHER'S MAIDEN NAME First: ELLEN Middle: M. Last: TRISH		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: no (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 214-01-6808D	17. INFORMANT: MRS. ANNA R. BARNHART	Address: 179 LONGVIEW AV. WESTMINSTER, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis
DUE TO, OR AS A CONSEQUENCE OF (b): Atherosclerotic Heart Disease
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): 4201

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from Feb 6, 1968, to Feb 14, 1968, that (I) (we) last saw the deceased alive on Feb 14, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (did) (~~did not~~) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
John S. Harshey M.D.		☒	☐	☐	2/14/68

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
JOHN S. HARSHEY, MD	8 Anders St Westminster Md

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	FEB. 17, 1968	KRIDERS CEMETERY	WESTMINSTER, CARROLL, MD.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
James C. Saffell Jr.	254 E. MAIN ST. WESTMINSTER, MD	FEB 16 1968	Charles Yingling

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02462 02448

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

1. DECEASED-NAME (Type or print) First / Middle / Last	CHARLES / EMANUEL / MACK	2a. DATE OF DEATH Month Day Year	February 25, 1968
		2b. HOUR	11:00 P.M.
3. SEX	Male	4. RACE	Negro
5. DATE OF BIRTH	6/24/06	6. AGE (In years last birthday)	61 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS		IF UNDER 24 HRS.: HOURS / MIN.	
7a. BIRTHPLACE (State or foreign country)	Maryland	7b. CITIZEN OF WHAT COUNTRY?	U.S.A.
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	separated	9. COUNTY OF DEATH	Carroll Md.
10. CITY OR TOWN OF DEATH	Sykesville	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	Springfield State Hospital
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	None	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	Maryland	13b. COUNTY	Baltimore
13c. CITY OR TOWN	~~Baltimore~~ Towson	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	
13e. STREET AND NUMBER	726 Boxley Avenue		
14. FATHER'S NAME First / Middle / Last	(unknown) Charles Mack	15. MOTHER'S MAIDEN NAME First / Middle / Last	Emma Mathews
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)	unknown No	16b. SOCIAL SECURITY NO.	unknown
17. INFORMANT Address	Records, Springfield State Hospital		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Lobar pneumonia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: days
481X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 490X
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
CBS, associated with presenile brain disease with psychotic reaction.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [X] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. **I certify** that (I) (this hospital) attended the deceased from 9/9/65, 19____, to 2/25/68, 19____, that (I) (we) last saw the deceased alive on 2/25/68 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	Octavio A Ruiz	DEGREE: ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS. [X]	22c. DATE SIGNED 2/26/68
22d. PHYSICIAN'S NAME (Type)	Octavio A. Ruiz, M.D.	22e. ADDRESS	Springfield State Hospital Sykesville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	Burial	23b. DATE	2/29/68	23c. NAME OF CEMETERY OR CREMATORY	Pleasant Rest
23d. LOCATION (City or Town) (County) (State)	Towson, Balto. co. Md				
24. FUNERAL DIRECTOR	Wm. L. Schatzmann	ADDRESS	1701 McCulloh St Baltimore	25a. REC'D BY REGISTRAR DATE	FEB 29 1968
25b. REGISTRAR'S SIGNATURE	[illegible]				

A34 4/19/68

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02463 02449

1. DECEASED-NAME (Type or Print): First HARRY Middle RUSSELL Last MALONE

2a. DATE KNOWN OF DEATH ☐ ESTIMATED ☒ Month 2 Day 16 Year 1968 — 2b. HOUR ? M

3. SEX: Male — 4. RACE: White — 5. DATE OF BIRTH: Sept. 3, 1906 — 6. AGE (In years last birthday): 61 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS: HOURS / MIN.

2c. DATE PRONOUNCED DEAD Month 2 Day 16 Year 1968 — 2d. HOUR 8:45 M

7a. BIRTHPLACE (State or foreign country): Maryland — 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. — 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ — 9. COUNTY OF DEATH: Carroll Md.

10. CITY OR TOWN OF DEATH: Union Bridge — 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Route 1 — 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Self — 12b. KIND OF BUSINESS OR INDUSTRY

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland — 13b. COUNTY: Carroll — 13c. CITY OR TOWN: Union Bridge — 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ — 13e. STREET AND NUMBER: Route 1

14. FATHER'S NAME First Middle Last: John J. Malone — 15. MOTHER'S MAIDEN NAME First Middle Last: Olivia C. O'Mara

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service) — 16b. SOCIAL SECURITY NO. — 17. INFORMANT ADDRESS: Gordon M. Malone 7732 Greenview Terrace

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis (Acute) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Sudden
4109
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4201

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH — 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 — 21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21e. PLACE OF INJURY (At hame, farm, street, factory, office building, etc.) — 21f. LOCATION Street ar R.F.D. Na. City or Town County State

22a. I certify that I took chorge of the remains described above, held an Autopsy ☐, Inspectian ☒, Inquiry ☐, and in my apinian death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Hamicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Wilton Speiches M.D.
EXAMINER'S NAME (Type)
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
ADDRESS (Street, city or town, or county): 135 E. Main St. Westminster Carroll

22b. DATE SIGNED 2-16-68

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE: 2-19-68 — 23c. NAME OF CEMETERY OR CREMATORY: Holy Redeemer — 23d. LOCATION (City or Town) (County) (State): Baltimore, Md.

24. FUNERAL DIRECTOR — ADDRESS: Mitchell-Wiedefeld Home, Inc. 6500 York Rd., Baltimore, Md. 21212

25a. REC'D BY REGISTRAR DATE FEB 21 1968 — 25b. REGISTRAR'S SIGNATURE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death unless any delay is necessary, please execute the certificate, writing the ward "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be farwarded to the Chief Medical Examiner's Office along with form 5 may be retained far yaur files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health priar to burial, crematian, ar removal, and in any event within 72 hours after death.

VR A15ME (5)
10M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02464

CERTIFICATE OF DEATH

02450

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
SAMUEL	(NMN)	MANNONE	February 26, 1968	7:10am.

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
Male	White	8/31/81	86 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
Italy	U.S.A.		Carroll Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Sykesville	Springfield State Hospital	Cement finisher	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Baltimore City	Baltimore	YES ☒ NO ☐	2926 Harford Road

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Frank Mannone			Mary		(Unk.)

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
None		218-09-8241	Records, Springfield State Hospital

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While ☐ Not while ☐ at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from 12/27/67, 19____, to 2/26/68, 19____, that (I) (we) last saw the deceased alive on 2/26/68 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Octavio A Ruiz		☐	☐	☒	2/26/68

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Octavio A. Ruiz, M.D.	Springfield State Hospital Sykesville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	3-1-68	Holy Redeemer Cemetery	Baltimore, Maryland

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
John C. Miller Inc-6415 Belair Road -21206	FEB 29 1968	Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02465 02451

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
EVELYN	JACKSON	MATHER	2	28	68	3:55 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.
FEMALE	WHITE	DEC. 4, 1908	59 YRS.				

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
WESTMINSTER MD.	U.S.A.		CARROLL CO. Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
WESTMINSTER	CARROLL CO GEN. HOSP.	LIBRARIAN	PUBLIC LIB.

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☑ NO ☐	13e. STREET AND NUMBER
MARYLAND	CARROLL	WESTMINSTER		121 WILLS ST.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
GEORGE K.		MATHER	NAN		RINKER

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
		220-28-3677	FRANK MATHER	LONGWELL AVE. WESTMINSTER MD

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) INTRACEREBRAL HEMORRHAGE — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 DAYS
4120
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b) HYPERTENSIVE CARDIOVASCULAR
DUE TO, OR AS A CONSEQUENCE OF (c) DISEASE — YEARS

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
443X

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from 2/25, 1968, to 2/28, 1968, that (I) (we) last saw the deceased alive on 2/28 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Vincent J. Knoll Jr		☐	☑	☐	2/28/68

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	3/1/68	WESTMINSTER CEMETERY	WESTMINSTER MD

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
J. S. Myers Jr.	Westminster, Md.	FEB 29 1968	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

02466

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02452

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
BEULAH	BLANCHE	MEAGHER	2	22	68	4:55 P.M.

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.
FEMALE	WHITE	FEB. 8, 1889	79 YRS.				

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐	9. COUNTY OF DEATH
CARROLL CO. MD.	U.S.A.		CARROLL Co. Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
WESTMINSTER	CARROLL Co. GEN. HOSP.	STOREKEEPER	SELF OPERATED

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MARYLAND	CARROLL	WESTMINSTER	YES ☑ NO ☐	276 E. MAIN ST.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
WILLIAM N.		SHAUCK	ELIZA		BARBER

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
	216-01-8530	Mrs. Roger T. Bruce	75 W. Pine St. Westminster Md

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Carcinomatosis

DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Carcinoma

DUE TO, OR AS A CONSEQUENCE OF (c) Endometrial Carcinoma

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1820

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

172

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☑	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from Feb. 20, 1968, to Feb 22, 1968, that (I) (we) last saw the deceased alive on Feb 22, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Charles Hawthorne Jr. M.D.	☒	☐	☐	Feb. 22, 1968

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	2/25/68	MT. PLEASANT CEMETERY	GAMBER, CARROLL Co. MD

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
J. S. Myers & Son, Westminster, Md.	FEB 26 1968	J. Charles Yingling

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 30M REV. 1/68

02467

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02453

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
Ida	Kate	Miller	2 13 68	1:30 pm

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
female	white	5/12/82	85 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
Maryland	USA		Carroll Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Bpral--Sykesville	Springfield State Hosp.	housewife	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Md.	Washington	Boonsboro	YES ☐ ? NO ☐	--

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
William ?		Boring	Anna	Margaret	Wolford ?

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
no	217-10-2748	Springfield Hospital records, Sykesville, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Congestive heart failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: days

DUE TO, OR AS A CONSEQUENCE OF

(b) Arteriosclerotic cardiovascular disease — years

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4129 4221

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Chronic brain syndrome with cerebral arteriosclerosis with psychotic reaction.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I **certify** that ☒ (this hospital) attended the deceased from 6/13/ , 1963 , to 2/13/ , 1968 , that ☒ (we) last saw the deceased alive on 2/13/ 1968 , and that in ☒ (our) opinion death occurred on the date and hour and from the causes stated above, ☒ (we) (did) ☐ view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Renato R. Espina		☐	☐	☒	2/13/68

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Renato R. Espina, M. D.	Springfield State Hospital Sykesville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	2/16/68	Rest Haven Cemetery	Hagerstown-Washington-Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Ralph M. Martin (Rest Haven Funeral Chapel)	Hagerstown Md	FEB 16 1968	Charles Suggs

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

02463

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02454

1. DECEASED-NAME (Type or Print) First: MALINDA	Middle: MAY	Last: MILLER	2o. DATE KNOWN OF DEATH ESTIMATED	Month: 2	Day: 2	Year: 1968	2b. HOUR: 11:30 AM
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH: May 31, 1889	6. AGE (In years last birthday) YRS.: 78	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	2c. DATE PRONOUNCED DEAD: Month 2 Day 2 Year 1968	2d. HOUR: 12:30 PM
7o. BIRTHPLACE (State or foreign country): Pa.	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Carroll Md.				
10. CITY OR TOWN OF DEATH: Westminster	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Rt. 1	12o. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife	12b. KIND OF BUSINESS OR INDUSTRY				
13o. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.	13b. COUNTY: Carroll	13c. CITY OR TOWN: Westminster	13d. INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET AND NUMBER: Rt. 1			
14. FATHER'S NAME First: Unknown	Middle	Last: Stuckey	15. MOTHER'S MAIDEN NAME First: Unknown	Middle	Last		
16o. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 212-24-5303	17. INFORMANT: George M. Miller	ADDRESS: Westminster, Md.			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Arteriosclerotic Cardiovascular disease — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 14yrs+

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

4129

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

4221

19o. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☒
21o. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State

22o. **I certify** that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Hamicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Wilson Speicher M.D.

EXAMINER'S NAME (Type)

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b. DATE SIGNED: 2-2-68

ADDRESS (Street, City or Town, County): 435 E. Main St. Westminster Carroll Md.

23o. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Feb. 5, 1968	Manchester Cemetery	Manchester Carroll Md.

24. FUNERAL DIRECTOR ADDRESS	25o. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Tipton - Eline Funeral Home Hampstead, Md.	FEB 7 1968	[illegible] Judge

VR A15ME (5)
10M REV. 1/68

02469

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02455

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

1. DECEASED-NAME (Type or print)	First: Lillie	Middle: Blanche	Last: Moser	2a. DATE OF DEATH: Month February Day 23 Year 1968	2b. HOUR: 10:15 AM	
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH: December 8, 1886	6. AGE (In years last birthday): 81 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	
7a. BIRTHPLACE (State or foreign country): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: Carroll Md.			
10. CITY OR TOWN OF DEATH: Middleburg	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Brookfield Manor Home	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife	12b. KIND OF BUSINESS OR INDUSTRY: None			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland	13b. COUNTY: Carroll	13c. CITY OR TOWN: Taneytown	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: George Street		
14. FATHER'S NAME First: Franklin	Middle	Last: Reaver	15. MOTHER'S MAIDEN NAME First: Ida	Middle: May	Last: Hess	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown): No	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 213-01-3778	17. INFORMANT: Mrs. Ralph Harver	Address: 31 George St, Taneytown, MD.		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebrovascular Accident — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 wk.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 437.9
DUE TO, OR AS A CONSEQUENCE OF (b): Cerebral atherosclerosis — Years
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
331X

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.	21f. LOCATION Street or R.F.D. No.	City or Town	County / State

22a. **I certify** that (I) (this hospital) attended the deceased from Dec 26, 19 67, to Feb 23, 19 68, that (I) (we) last saw the deceased alive on Feb 23, 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: J. H. Caricofe	DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22c. DATE SIGNED: 2/23/68			
22d. PHYSICIAN'S NAME (Type): J. H. Caricofe	22e. ADDRESS: Union Bridge, Maryland				

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 2/26/68	23c. NAME OF CEMETERY OR CREMATORY: Piney Creek Cemetery	23d. LOCATION (City or Town) (County) (State): Taneytown, Carroll, Maryland	
24. FUNERAL DIRECTOR: C.O. Fuss & Son, John H. Skiles	ADDRESS: Taneytown, Md.	25a. REC'D. BY REGISTRAR DATE: FEB 26 1968	25b. REGISTRAR'S SIGNATURE: Charles Unger	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02470

CERTIFICATE OF DEATH

02456

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
WILLIAM	VINCENT	MURPHY	FEBRUARY 26, 1968	2:15 AM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
Male	White	1876	92 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
Maryland	U.S.A.	NEVER MARRIED [X]	Carroll Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Sykesville	Springfield State Hospital	Laborer	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Baltimore City	Baltimore	YES [X] NO [ ]	1523 W. Pratt St.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Patrick		Murphy	Margurite		Tiarny

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
NO	220-54-6597	Records, Springfield State Hospital

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Years

4129

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

4221

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [X]	

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from 11-1-04, 19____, to 2-26-68, 19____, that (I) (we) last saw the deceased alive on 2-26-68 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Octavio A Ruiz MD				[X]	2-26-68

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Octavio A. Ruiz, M. D.	Springfield State Hospital Sykesville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	2-29-68	St. Michaels Cemetery	Howard Co. Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Harry W. Haight	Sykesville, Md.	FEB 29 1968	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1768

1

02471

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02457

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
Hobart		Ogle	February 8, 1968	5:45 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
Male	White	10-30-92	75 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
Maryland	U.S.A.		Carroll Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Sykesville	Springfield State Hosp.	none	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	BALTO	Baltimore	YES ☐ NO ☐	2221 Old Frederick Road

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Joseph Ogle			Anna Wagner		

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
No	220-54-6593	Records, Springfield State Hospital

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiorespiratory arrest.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 250.9
DUE TO, OR AS A CONSEQUENCE OF (b) cardiac failure.
DUE TO, OR AS A CONSEQUENCE OF (c) diabetes.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
none 260 X

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While ☐ at work Not while ☐ at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from 7-16, 1943, to 2-8, 1968, that (I) (we) last saw the deceased alive on 2-8 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
[signature]	M.D.	☐	☐	☒	2-8-68

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Othon Tirado, M.D.	

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	2-10-68	Woodlawn Cem.	Woodlawn Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Farley-Cavanaugh & Hs Catonsville Md	FEB 13 1968	Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02472

CERTIFICATE OF DEATH

02458

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
Mary	Elizabeth	Orem	2	1	68	9:45 AM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS	DAYS	IF UNDER 24 HRS.: HOURS	MIN.
Female	White	4-12-1884	83 YRS.				

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
Maryland	U.S.A.		Carroll Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Sykesville	Springfield State Hospital	Textile worker	--

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Baltimore City	Baltimore	YES ☒ NO ☐	1426 Morling Avenue

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
John A John	Andrews	Myers	Anna	-	Souder

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
No		213-03-4311	Records, Springfield State Hospital	Sykesville, Maryland 21784

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Bronchopneumonia — Approximate interval between onset and death: Days

4129

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4200

DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease — Years

DUE TO, OR AS A CONSEQUENCE OF (c) Generalized arteriosclerosis — Years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Diabetes Mellitus

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (X) (this hospital) attended the deceased from January 5, 1968, to February 1 19 68, that (X) (we) last saw the deceased alive on February 1 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Dr. Antonius Glahn		☐	☐	☒	2/1/68

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Antonius Glahn, M.D.	Springfield State Hospital Sykesville, Maryland 21784

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Feb 5, 1968	Baltimore	E. North Ave Md

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Austin E. Donovan	3818 Roland Ave	FEB 5 1968	Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02473 02459

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires thot the deoth certificate be executed within 24 haurs after death. Page 4 may be retoined by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificote has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use os the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to buriol, cremotion, or removol, and in ony event, within 72 hours after death.

VR A15 (4) 30M REV. 1/68

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
Dr. Julian		Radzykewycz	Feb.	4.	1968	12. Noon M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
Male	White	7-4-1900	67 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
Ukraine	USA		Carroll Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Sykesville	In Office Springfield	Medical Doctor	Medical

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Md.	Carroll	Sykesville	YES ☐ NO ☒	Emeral Valley

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Peter	Radzykewycz		Volodymyra	Piaceck	

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
No	----	219 36 1666	Mrs. Antonia Radzykewycz Sykesville

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Minutes
4129
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(b) Arteriosclerotic cardiovascular disease — Years
DUE TO, OR AS A CONSEQUENCE OF
(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4330

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from 12-15-67, 19___, to 2-4-68, 19___, that (I) (we) last saw the deceased alive on 2-1-68 19___, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Octavio A Ruiz M.D.		☒	☐	☐	2-6-68

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Octavio A. Ruiz, M. D.	Springfield State Hospital Sykesville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	2-7-68	Lake View Cemetery	Sykesville Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Harry W. Haight	Sykesville, Md.	FEB 9 1968	Charles Yingling

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02474 02460

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
SUSAN	EVELYN	REESE	February 18, 1968	6 A M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
female	white	Sept. 17, 1903	64 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
Carroll Co.,	Md. U.S.A.		Carroll County Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Sykesville	Springfield State Hosp.	Beautician	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Carroll	Westminster	YES ☐ NO ☒	

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
John	Thomas	Fritz	Laura		Myerly

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give wor or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
	215-26-1873	Springfield State Hospital, Sykesville, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Bilateral Lobular Pneumonia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

481X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 490X

DUE TO, OR AS A CONSEQUENCE OF (b) — Days

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) reaction.
CBS assoc. with presenile brain disease(Alzheimer's)with psychotic

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☒ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical exominer)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** thot (I) (this hospitol) attended the deceased from 12-2-66, 19____, to 2-18-68, 19____, thot (I) (we) lost sow the deceased olive on 2-18-68 19____, ond thot in (my) (our) opinion deoth occurred on the dote and hour ond from the couses stoted above, (I) (we) (did) (did not) view the body ofter deoth.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Seock C Chang		☐	☐	☒	2-18-68

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Seock C. Chang, M.D.	Springfield State Hospital Sykesville, Maryland 21784

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	2/20/68	Pipe Creek Cemetery	Rural new Windsor Md

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
L. E. Myers & Son	Westminster Md	FEB 23 1968	Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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30M REV. 1/68

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02475

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02461

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First: DORETHENE	Middle: E.	Last: RIGLER	2a. DATE OF DEATH Month: February Day: 26 Year: 1968
2b. HOUR: 2:35 PM			
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH: April 23, 1910	6. AGE (In years last birthday): 57 YRS. IF UNDER 1 YEAR: MONTHS / DAYS IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (State or foreign country): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: Carroll Md.
10. CITY OR TOWN OF DEATH: Mt. Airy	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): Route 2	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife	12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland	13b. COUNTY: Carroll	13c. CITY OR TOWN: Mt.Airy	13d. INSIDE CITY LIMITS? YES [ ] NO [X] — 13e. STREET AND NUMBER: Route 2
14. FATHER'S NAME First: William	Middle:	Last: Wright	15. MOTHER'S MAIDEN NAME First: Stella Middle: M. Last: Farver
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No	16b. SOCIAL SECURITY NO.: 217-28-0928	17. INFORMANT: Mr. Percy W. Rigler	Address: Same As #13

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Arteriosclerotic Cardiovascular Disease — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 9 Yrs yrs

4129

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

4221

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medicol examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While [ ] at work Not while [ ] at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. **I certify** thot (I) (this hospitol) ottended the deceased from March, 1965, to Feb, 1968, thot (I) (we) last saw the deceased alive on Feb 25 1968, and thot in (my) (our) opinion deoth occurred on the date ond hour ond from the couses stoted obove, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: W.B. Culwell	DEGREE: ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]	22c. DATE SIGNED: Feb 27, 1968	
22d. PHYSICIAN'S NAME (Type): W.B. Culwell	22e. ADDRESS: Mt. Airy, Maryland		

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 2/28/1968	23c. NAME OF CEMETERY OR CREMATORY: Taylorsville Cemetery	23d. LOCATION (City or Town) (County) (State): Carroll Co., Md.	
24. FUNERAL DIRECTOR: C. M. Waltz, Box 241, Sykesville, Md.	ADDRESS	25a. REC'D BY REGISTRAR DATE: FEB 29 1968	25b. REGISTRAR'S SIGNATURE: J. Charles Jones	

VR A15 (4)
30M REV. 1/68

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02476

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02462

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Last
ELWOOD	JASPER	SCHAEFFER

2a. DATE OF DEATH Month	Day	Year	2b. HOUR
2	25	68	10:15 M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.
Male	Caucasian	9/15/86	81 YRS.				

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
Maryland	U. S. A.	NEVER MARRIED [X]	Carroll Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12a. USUAL OCCUPATION (Kind of wark done during most of warking life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Sykesville	Springfield State Hosp.	Farm hand	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Md.	Frederick	Frederick	YES [ ] NO [X]	

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Jasper	E.	Schaeffer	Sarah	E.	Stockman

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, ar unknawn) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
no	220-54-6916	Hospital Records

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter anly ane cause per line far (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Bronchopneumonia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: days

DUE TO, OR AS A CONSEQUENCE OF (b) Cerebro-vascular accident-thrombosis — months

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gove rise to immediote couse (a), stating the underlying couse lost. 4339 3322

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

CBS assoc. with Birth Trauma with psychotic reaction

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [X]	

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, natify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Manth Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at wark [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street ar R.F.D. No.	City or Town	County	State

22a. **I certify** thot (I) (this hospital) attended the deceased from 9/11/28, 19____, to 2/25/68, 19____, that (I) (we) last sow the deceased alive an 2/25/68 19____, and that in (my) (our) apinion deoth occurred on the date and haur and fram the causes stated above. (I) (we) (did) (did not) view the body after deoth.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
[signature]		[ ]	[ ]	[X]	2/26/68

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Andres Ramos, M. D.	Springfield State Hospital

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City ar Tawn)	(County)	(State)
Burial	2-28-68	St Lukes Lutheran	Frederick	Co.	Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Harry W. Haight	Sykesville, Md.	FEB 29 1968	[signature]

VR A15 (4)
30M REV. 1/68

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health priar to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02477 02463

5:15

1. DECEASED-NAME (Type or Print) First: MARY LANE Middle: Last: SCHAFFER					2a. DATE KNOWN OF DEATH ESTIMATED ☐: Month 2 Day 20 Year 1968	2b. HOUR P M	
3. SEX: female	4. RACE: white	5. DATE OF BIRTH: Oct. 3, 1901	6. AGE (In years last birthday): 66 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.		2c. DATE PRONOUNCED DEAD Month 2 Day 20 Year 1968	2d. HOUR 5:30 P M	
7a. BIRTHPLACE (State or foreign country): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Carroll County Md.				
10. CITY OR TOWN OF DEATH: Westminster	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): DOA Carroll County General Hospital	12a. USUAL OCCUPATION (Kind of work done most of working life, even if retired.): Housewife	12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland	13b. COUNTY: Carroll	13c. CITY OR TOWN: Westminster	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: 48 Longwell Ave.			
14. FATHER'S NAME First: Joseph Middle: E. Last: Lane		15. MOTHER'S MAIDEN NAME First: Sallie Middle: Bowen Last:					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 212-05-6672A	17. INFORMANT: Charles D. Schaffer	ADDRESS: same			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Fractured skull and multiple injuries — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: sudden
DUE TO, OR AS A CONSEQUENCE OF (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying couse last.
DUE TO, OR AS A CONSEQUENCE OF (c):

8129

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

8164

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☒	
21a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 5:15 2-20 1968	21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.) car crossed center lane & struck oncoming	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) state highway	21f. LOCATION Street or R.F.D. No. / City or Town / County / State: Rte 140 east of Westminster Carroll Md	

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: W. Glenn Speicher M.D.
EXAMINER'S NAME (Type): W. Glenn Speicher, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
22b. DATE SIGNED: 2-20-68
ADDRESS (Street, city, town, or county): 135 E. Main St. Westminster, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): burial	23b. DATE: Feb. 23, 1968	23c. NAME OF CEMETERY OR CREMATORY: Baldwin Memorial Cemetery	23d. LOCATION (City or Town) (County) (State): Millersville, Md.	
24. FUNERAL DIRECTOR: J. L. Myers, Jr.	ADDRESS: Westminster, Md.	25a. REC'D BY REGISTRAR DATE: MAR 6 1968	25b. REGISTRAR'S SIGNATURE	

VR A15ME (5)
10M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02473

CERTIFICATE OF DEATH

02464

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Grand View Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Balto. Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Reisterstown
d. STREET ADDRESS: 2 Shirley Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Tilly — Middle: A. — Last: Shipley

4. DATE OF DEATH: Month: Feb. — Day: 14, — Year: 19 68

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Feb. 9, 1881

9. AGE (In years last birthday): 87 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Carroll Co. Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Thomas Lowe

14. MOTHER'S MAIDEN NAME: Alice Hann

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): NO

16. SOCIAL SECURITY NO.: 216-48-2486

17. INFORMANT — Address: Mrs. Tilly Bates Reisterstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hypertensive Cardiovascular Disease — INTERVAL BETWEEN ONSET AND DEATH: 20 yrs.
4120
DUE TO (b): General arteriosclerosis — 20 yrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Advanced Senile Changes

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 443 X

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 24/Oct/65, 19__, to 14/Feb/68 19__, that (I) (we) last saw the deceased alive on 14/Feb/68 19__, and that death occurred at 6:45 AM from causes and on the date stated above.

22a. SIGNATURE: Wm. H. Lawson, Jr., M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 14/Feb/68

22c. PHYSICIAN'S NAME (Type): Wm. H. Lawson, Jr., M. D.

22d. ADDRESS: Box 54, RD #2, Sykesville, Md. 21784

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Feb. 17, 1968

23c. NAME OF CEMETERY OR CREMATORY: Greenmount Cemetery

23d. LOCATION (City or Town) (County) (State): Greenmount Carroll Co. Md.

24. FUNERAL DIRECTOR — ADDRESS: Tipton - Eline Funeral Home Hampstead, Md.

25a. REC'D BY REGISTRAR DATE: FEB 19 1968

25b. REGISTRAR'S SIGNATURE:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

02479

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02465

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
Isaac	NMN	Solomon	2 13 68	1:50PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
Male	White	9-XX-1867 X 18-1890	77XX YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
RUSSIA ~~Poland~~	U.S.A.	MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	Carroll Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life)	12b. KIND OF BUSINESS OR INDUSTRY
Sykesville	Springfield State Hospital	~~MERCHANT~~ Retired (store owner)	CREDIT STORE

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Md.	Balto. City	Baltimore	YES ☒ NO ☐	2408 Brookfield Avenue

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
~~Morris~~ UNKNOWN		~~Solomon~~	~~Hannah~~ UNKNOWN		

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
No	216-54-2684	MR. JEROME STULMAN, 30 E. BALTIMORE STREET Records, ~~Springfield State Hosp, Sykes., Md.~~ #2

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Pulmonary Uremia

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Hypertensive Arteriosclerotic Cardiovascular disease

DUE TO, OR AS A CONSEQUENCE OF (c) Generalized Arteriosclerosis

4120

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

443X

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from 8-15, 19 67, to 2-13-, 19 68, that (I) (we) last saw the deceased alive on 2-13-68 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. 1:50 PM - 13 Feb. 68

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
H E Connor MD		☐	☐	☒	13 Feb 1968

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Huell E. Connor, M.D.	Springfield State Hospital, Sykes., Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	2-14-68	HEBREW FRIENDSHIP	BALTIMORE, MARYLAND

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD	FEB 14 1968	Charles Judge

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02480 02466

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: Frances	Middle: Theresa	Last: Sommers	2a. DATE OF DEATH: Month 2 Day 3 Year 68	2b. HOUR: 7:30 pm	
3. SEX: female	4. RACE: white	5. DATE OF BIRTH: 2/14/12	6. AGE (In years last birthday): 55 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	
7a. BIRTHPLACE (State or foreign country): Maryland	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Carroll Md.			
10. CITY OR TOWN OF DEATH: Rural--Sykesville	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Springfield State Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): none	12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.	13b. COUNTY: Baltimore	13c. CITY OR TOWN: Dundalk	13d. INSIDE CITY LIMITS? YES ☐ NO ☐ ?	13e. STREET AND NUMBER: German Hill Road		
14. FATHER'S NAME First: Frank	Middle	Last: Sommers	15. MOTHER'S MAIDEN NAME First: Stella	Middle	Last: Napraski	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown): no (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: none	17. INFORMANT Address: Springfield Hospital records, Sykesville, Md.				

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardiac failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4369 331 X

DUE TO, OR AS A CONSEQUENCE OF (b): Cerebrovascular accident — weeks

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Mental deficiency, idiopathic, severe.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, natify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** thot ☒ (this hospitol) ottended the deceosed from 8/7/ , 1947 , to 2/3/ , 1968 , that ☒ (we) last sow the deceased alive on 2/3/ 1968 , and that in ~~(my)~~ (our) opinion death occurred an the date ond haur and from the couses stated obave, ☒ (we) (did) ~~(did not)~~ view the body after death.

22b. SIGNATURE	DEGREE				22c. DATE SIGNED
Naci N Buyukunsal M.D.	ATTENDING PHYS. ☐	MED. DIRECTOR ☐	STAFF PHYS. ☒		2/3/68
22d. PHYSICIAN'S NAME (Type): Naci N. Buyukunsal, M.D.	22e. ADDRESS: Springfield State Hospital Sykesville, Maryland				

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL	23b. DATE: 2-6-68	23c. NAME OF CEMETERY OR CREMATORY: New Freedom	23d. LOCATION (City or Town): Sykesville (County): (State): Md.
24. FUNERAL DIRECTOR: Harry W. Haight	ADDRESS: Sykesville	25a. RECD BY REGISTRAR DATE: FEB 6 1968	25b. REGISTRAR'S SIGNATURE: J. Charles Jones

VR A15 (4) 30M REV. 1/68

02481

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02467

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
Edna	--	Spedden	2 Month 7 Day 68 Year	12 noon M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
female	white	6/4/1889	78 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
Maryland	USA	NEVER MARRIED [X]	Carroll Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Rural--Sykesville	Springfield State Hospital	seamstress	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	-	Baltimore	YES / NO	unknown

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Edward Spedden			Ella		Travers

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
no	none	Springfield Hospital records, Sykesville, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: hours

4109

Conditions, if ony, which gove rise to immediate cause (a), stoting the underlying cause lost. 4201

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Schizophrenic reaction, hebephrenic type.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES / NO [X]	

21a. ACCIDENT WAS UNDERLYING	21b. TIME OF INJURY	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)
OR CONTRIBUTING / CAUSE OF DEATH (If either, natify medicol examiner)	HOUR A.M. P.M. Manth Day Yeor 19	

21d. INJURY OCCURRED While at work / Not while at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I **certify** that ~~I~~ (this haspital) attended the deceased from 3/27/, 1918, to 2/7/, 1968, thot ~~I~~ (we) last saw the deceased olive an 2/7/ 1968, and thot in ~~my~~ (our) opinion deoth occurred an the date ond hour ond from the causes stated abave, ~~I~~ (we) (did) ~~did not~~ view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Edmee J. Reeves MD				[X]	2/7/68

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Edmee J. Reeves, M. D.	Springfield State Hospital Sykesville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Feb 9 , 1968	Greenlawn Cemetery	Cambridge, Maryland

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
LeCompte Funeral Service, Cambridge, Maryland	FEB 13 1968	Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02482 02468

FOR STATE HEALTH DEPT.

1. DECEASED-NAME (Type or Print): First ELWOOD Middle HAROLD Last STEMPLE
2a. DATE OF DEATH KNOWN ☒ ESTIMATED ☐: Month 2 Day 4 Year 1968
2b. HOUR 1:15 P.M.
3. SEX: MALE
4. RACE: WHITE
5. DATE OF BIRTH: SEPT. 3 1927
6. AGE (In years last birthday): 40 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS.: HOURS MIN.
2c. DATE PRONOUNCED DEAD: Month 2 Day 4 Year 1968
2d. HOUR 1:15 P.M.
7a. BIRTHPLACE (State or foreign country): GARRETT Co. MD. U.S.A.
7b. CITIZEN OF WHAT COUNTRY? U.S.A.
8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
9. COUNTY OF DEATH: CARROLL CO. Md.
10. CITY OR TOWN OF DEATH: WESTMINSTER
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): 88 W. MAIN ST.
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): LABORER
12b. KIND OF BUSINESS OR INDUSTRY: LANDSCAPING
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland
13b. COUNTY: Carroll
13c. CITY OR TOWN: Westminster
13d. INSIDE CITY LIMITS? YES ☐ NO ☐
13e. STREET AND NUMBER: 88 W. Main Street
14. FATHER'S NAME: First CLARENCE Middle GROVER Last STEMPLE
15. MOTHER'S MAIDEN NAME: First ELSIE Middle JANE Last ?
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service): —
16b. SOCIAL SECURITY NO.: 213-24-7302
17. INFORMANT: MRS. ELWOOD H. STEMPLE ADDRESS: 88 W. MAIN ST. WESTMINSTER MD

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Knife Wound Heart (Self Inflicted) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 20 Min
DUE TO, OR AS A CONSEQUENCE OF
(b):
DUE TO, OR AS A CONSEQUENCE OF
(c):
956 X
Conditions, if any, which gave rise to immediate couse (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
977 X

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?
20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH
21b. TIME OF INJURY Manth, Day, Yeor: HOUR A.M. 1:00 P.M. 2-4 1968
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.): Self Inflicted Knife Wound Heart
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.): Hes Home
21f. LOCATION Street or R.F.D. No.: 88 W Main City or Town: Westminster County: Carroll Stat: Md

22o. **I certify** thot I took chorge of the remains described obove, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinian death resulted from: ~~Natural causes~~ ☐, Accident ☐, Suicide ☒, Homicide ☐, Undefermined manner ☐

ACTUAL SIGNATURE: W. Glenn Speicher M.D.
EXAMINER'S NAME (Type)
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
22b. DATE SIGNED 2-4-68
ADDRESS (Street, town, or county): 88 E Main Westminster, Carroll Md

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE: 2/8/68
23c. NAME OF CEMETERY OR CREMATORY: WESTMINSTER CEMETERY
23d. LOCATION (City or Town) (County) (State): WESTMINSTER, MD
24. FUNERAL DIRECTOR: J. S. Myers Jr. ADDRESS: Westminster, Md.
25o. REC'D BY REGISTRAR DATE: FEB 7 1968
25b. REGISTRAR'S SIGNATURE: Charles Jones

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM2. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

A34 4/19/68

VR A15ME (5) 10M REV. 1/68

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02483 02469

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
Stevens,	Dora	Elizabeth	2 23 68	2:30 pm

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
female	Negro	5/29/16	51 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
Maryland	USA		Carroll Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12a. USUAL OCCUPATION (Kind of wark done during mast of warking life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Rural--Sykesville	Springfield State Hospital	domestic	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence-before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER
Maryland	C	Baltimore		1200 N. Stricker St.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Levin	?	Stevens	Minnie	Ann	Johnson

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, ar unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
no	none known	Springfield Hospital records, Sykesville, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cerebrovascular accident — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: hours

4369

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 331x

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Schizophrenic reaction, chronic undifferentiated type. Chronic brain syndrome with alcohol intoxication without qualifying phrase.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol exominer)	21b. TIME OF INJURY HOUR A.M. P.M. Manth Doy Yeor 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 ar Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	Stote

22a. I **certify** thot ~~I~~ (this haspital) attended the deceased from 10/28/ 1965, to 2/23/ 1968, that ~~I~~ (we) last saw the deceased alive an 2/23/ 1968, and that in ~~my~~ (aur) apinian death occurred an the date and hour and from the causes stated abave, ~~I~~ (we) (did) (~~did not~~) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS. ☐	MED. DIRECTOR ☐	STAFF PHYS. ☒	22c. DATE SIGNED
Naci N. Buyukunsal, M.D.					2/23/68

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Naci N. Buyukunsal, M.D.	Springfield State Hospital Sykesville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
	2-26-68	U. Md. Med. School	Baltimore, Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Newell Funeral Home	P.E. M.	FEB 29 1968	Charles Jones

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02484

CERTIFICATE OF DEATH

02470

1. DECEASED-NAME (Type or print) First	Middle	Last	2o. DATE OF DEATH Month	Day	Year	2b. HOUR
CHARLES	HENRY	STOCK	2	12	68	9:40 M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.
Male	Caucasian	11/03/88	79 YRS.				

7o. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	9. COUNTY OF DEATH
Penna	U.S.A.		CARROLL Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12o. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Sykesville	Springfield State Hospital	Laborer	

13o. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Balto City		YES ☒ NO ☐	510 W. Fayette Street

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
William ~~ROPE~~	H.	STOCK	ELIAZBETH		MOORE

16o. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
		212-07-3622	Hospital records	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (o), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o) Coronary artery heart disease
DUE TO, OR AS A CONSEQUENCE OF (b) Bilateral bronchopneumonia
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if ony, which gove rise to immediote couse (o), stoting the underlying couse lost. 4129 4201

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Years / Days

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)
1. Schiz. reaction, acute undiff. type 2. Mental Defective Undifferentiated

19o. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20o. AUTOPSY? YES ☒ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
			yes

21o. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol exominer)	21b. TIME OF INJURY HOUR A.M. P.M. Month Doy Yeor 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While ☐ at work Not while ☐ at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that ~~I~~ (this hospitol) attended the deceased from 6/61, 1957, to 2/12, 1968, that ~~I~~ (we) last saw the deceased alive on 2/12/ 1968, and thot in ~~my~~ (our) opinion deoth occurred on the date ond hour and from the couses stoted above; ~~I~~ (we) (did) ~~did not~~ view the body after death.

22b. SIGNATURE	DEGREE ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒	22c. DATE SIGNED
Suha Ozgun.		2-13-68

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Suha Ozgun, M.D.	Springfield State Hosp., Sykesville, Md.

23o. BURIAL, ~~CREMATION~~, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town)	(County)	(State)
	2/14/68	St. Patricks	York,	York,	Pa.

24. FUNERAL DIRECTOR	ADDRESS	25o. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Harry W. Haight	Sykesville, Md.	FEB 15 1968	Deputy Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the deoth certificote be executed within 24 hours after deoth. Page 4 moy be retoined by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate hos been signed by the attending physician ond completely filled in by the funeral director, page 3 should be detached for use as the buriol-transit permit. Then please remove corbon popers. Pages 1 and 2 should be filed with the State Dept. of Health prior to buriol, cremotion, or removal, and in any event, within 72 hours after deoth.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02485

CERTIFICATE OF DEATH

02471

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
Ezra	David	Stuller	2 26 68	1:55 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
Male	White	August 13, 1909	58 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH
Maryland	U.S.A.		Carroll Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Westminster	Carroll Co. General Hosp.	Estimator	Construction

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	—	Baltimore	YES [X] NO [ ]	2800 West Rodgers Ave.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Edward	Ezra	Stuller	Flora	L.	Fowble

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
No	220-03-0082	Mrs. Homer Y. Myers, R#1, Taneytown, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	CONGESTIVE HEART FAILURE	6 WKS
DUE TO, OR AS A CONSEQUENCE OF (b)	HYPERTENSIVE CARDIOVASCULAR DISEASE	YEARS
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4120

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

443X

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I **certify** that (I) (this hospital) attended the deceased from 2/4, 1968, to 2/26, 1968, that (I) (we) last saw the deceased alive on 2/26 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Vincent J. Fiocco, Jr.	MD	[X]	[ ]	[ ]	2/26/68

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Vincent J. Fiocco, Jr.	Westminster, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	2/29/68	Lutheran Cemetery	Uniontown, Carroll, Maryland

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
John H. Skiles C.O. Fuss & Son, John H. Skiles, Taneytown, Md.	FEB 28 1968	J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

1

02486

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02472

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
Ada	NMN	Turner	2	6	68	11 a.m

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 1 YEAR DAYS	IF UNDER 24 HRS. HOURS	IF UNDER 24 HRS. MIN.
Female	Negro	6-11-01	66 YRS.				

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
unknown	unknown		Carroll County, Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Sykesville	Springfield State Hosp.	unknown	unknown

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Md.	Balt. City -	Baltimore	YES ☒ NO ☐	2117 Denison Street

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
unknown			unknown		

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
no	219-22-6699	Records, Springfield State Hosp., Sykesvil

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Myocardial infarction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: minutes

174X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 170x

DUE TO, OR AS A CONSEQUENCE OF (b) Arrested pulmonary disease — years

DUE TO, OR AS A CONSEQUENCE OF (c) Radical mastectomy, left, for breast cancer — years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Chronic brain syndrome associated with Huntington's Chorea, with psychotic reaction.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Manth Doy Yeor 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Port 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this haspital) attended the deceased from October 18, 19 67, to February 6 19 68, that (I) (we) last saw the deceased alive on February 6 19 68, and that in (my) (our) opinion death occurred an the date and hour and from the causes stated abave, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Irfan Esendal M.D.		☐	☐	☒	2-6-68

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Irfan Esendal, M.D.	Springfield State Hospital Sykesville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
	2/8/68	U. of Md. Med. School	Baltimore, Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Revell Funeral Home	Sykesville, Md.	FEB 13 1968	Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

Item 16 film 3 pg 2-26-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02487 02473

1. DECEASED-NAME (Type or print)	First: DAVID	Middle: W	Last: WAGNER	2a. DATE OF DEATH Month: 2 Day: 11 Year: 68	2b. HOUR: M	
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: Nov. 13, 1892	6. AGE (In years last birthday): 75 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: CARROLL Md.			
10. CITY OR TOWN OF DEATH: Westminster	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Carroll Co. General Hospt.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Farmer	12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.	13b. COUNTY: Balto. Co.	13c. CITY OR TOWN: Hampstead	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET AND NUMBER: Rt. 2		
14. FATHER'S NAME First: George	Middle	Last: Wagner	15. MOTHER'S MAIDEN NAME First: Rebecca	Middle	Last: Leppo	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: NO (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 217-36-4509 A	17. INFORMANT Address: Myrtle Wagner Rt. 2 Hampstead, Md.				

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CARCINOMATOSIS. Pancreas — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 YEAR.
157.9
DUE TO, OR AS A CONSEQUENCE OF (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
157X

19a. DATE OF OPERATION: None	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☒ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY Ooccurred (Enter nature of injury in Part I or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. **I certify** that (I) (~~this hospital~~) attended the deceased from 1/30, 19 68, to 2/11, 19 68, that (I) (~~we~~) last saw the deceased alive on 2/11, 19 68, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (did) (~~did not~~) view the body after death.

22b. SIGNATURE: Richard Y. Dalrymple M.D. DEGREE — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22c. DATE SIGNED

22d. PHYSICIAN'S NAME (Type): RICHARD Y. DALRYMPLE — 22e. ADDRESS: 187 E. MAIN ST. WESTMINSTER, MD

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Feb. 14, 1968	Greenmount Cemetery	Hampstead Carroll Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Tipton - Eline Funeral Home Hampstead, Md.	FEB 14 1968	Deputy Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02488 02474

1. DECEASED-NAME (Type or print) First	Middle	Lost	2o. DATE OF DEATH Month Day Year	2b. HOUR
Elizabeth	Marguerite	Weisenmiller	2- 19 68	3:10a M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
Female	Caucasion	3-17-02	65 YRS.		

7o. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
Maryland	U.S.A.		Carroll County Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12o. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Sykesville	Springfield State Hospital	None	None

13o. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Allegany	Cumberland	YES ☒ NO ☐	556 Green Street

14. FATHER'S NAME First	Middle	Lost	15. MOTHER'S MAIDEN NAME First	Middle	Lost
Jacob		Weisenmiller	Eleanor		Yupa

16o. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
No		213-58-2736	Springfield Hospital Records	Sykesville, Maryland

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (o), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (o) Chronic rheumatic and arteriosclerotic heart

DUE TO, OR AS A CONSEQUENCE OF disease

Conditions, if any, which gave rise to immediate couse (o), stating the underlying couse last. 398 X 416 X

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE ORCONDITION GIVEN IN PART 1(o)

Chronic Brain Syndrome associated with Convulsive disorder with psychotic reaction 16.01

19o. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20o. AUTOPSY? YES ☒ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
			yes

21o. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol exominer)	21b. TIME OF INJURY HOUR A.M. P.M. Month Doy Yeor 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port I or Port 2, Item 18.)

21d. INJURY OCCURRED While ot work ☐ Not while ot work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	Stote

22a. **I certify** that ☒ (this hospital) attended the deceased from 8-12-54, 19__, to 2-19-, 1968, that ☒ (I) (we) last saw the deceased alive an 2-19- 1968, and that in (my) (our) apinion death accurred an the date and haur and fram the causes stated abave, (I) (We) (did) (☒ Did Not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS. ☐	MED. DIRECTOR ☐	STAFF PHYS. ☒	22c. DATE SIGNED
Isak Hapner					2-19-68

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Isak Hapner M.D.	Springfield St. Hosp. Sykesville, Md.

23o. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	2/22/68	St. Peter & Paul's	Cumberland Md

24. FUNERAL DIRECTOR	ADDRESS	25o. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Louis Stein Inc.	Cumb. Md.	FEB 23 1968	Charles Jones

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physicion and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02489 (M) 02475

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: SARAH	Middle: S.	Last: WENGER	2a. DATE OF DEATH Month: FEB. Day: 3 Year: 68	2b. HOUR: 11:45 A M	
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH: SEPT. 18 1896	6. AGE (In years last birthday): 71 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	
7a. BIRTHPLACE (State or foreign country): PENNA.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐	9. COUNTY OF DEATH: CARROLL CO. Md.			
10. CITY OR TOWN OF DEATH: WESTMINSTER RT#2	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address):	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): HOUSE-WIFE	12b. KIND OF BUSINESS OR INDUSTRY:			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: PENNA.	13b. COUNTY: LEBANON	13c. CITY OR TOWN: ANNVILLE	13d. INSIDE CITY LIMITS? YES ☐ NO ☑	13e. STREET AND NUMBER: RT#1		
14. FATHER'S NAME First: DANIEL	Middle:	Last: FUNK	15. MOTHER'S MAIDEN NAME First: PHRANEY	Middle:	Last: SMITH	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: — (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: —	17. INFORMANT: MRS. JOSEPH WENGER	Address: WESTMINSTER RT#2, MD.			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ACUTE CORONARY occlusion with M.I. — 410.9
DUE TO, OR AS A CONSEQUENCE OF
(b): Arteriosclerotic Cardiovascular Disease
DUE TO, OR AS A CONSEQUENCE OF
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4201

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
acute bronchitis

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County / State

22a. **I certify** that (I) (~~this hospital~~) attended the deceased from 1-23, 1968, to 2-3, 1968, that (I) (~~we~~) last saw the deceased alive on 2-3 1968, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (did) (~~did not~~) view the body after death.

22b. SIGNATURE: Philip W. Mercer	DEGREE: ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐	22c. DATE SIGNED: 2/3-68	
22d. PHYSICIAN'S NAME (Type): PHILIP W. MERCER	22e. ADDRESS: W. MAIN ST. WESTMINSTER, MD.		

23a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL	23b. DATE: 2/7/68	23c. NAME OF CEMETERY OR CREMATORY: GRAVEL HILL CEMETERY	23d. LOCATION (City or Town) (County) (State): PALMYRA PENNA.	
24. FUNERAL DIRECTOR: J. E. Myers, Jr.	ADDRESS: WESTMINSTER, MD.	25a. REC'D BY REGISTRAR DATE: FEB 5 1968	25b. REGISTRAR'S SIGNATURE: J. Charles Judge	

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02490

CERTIFICATE OF DEATH

02476

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
Mary	Genevieve Hudgel	Westenhaver	Feb.	24	68	10:50 P.M.

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.
Female	White	1-15-88	80 YRS.				

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
West Virginia	U.S.A.		Carroll Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Sykesville	Springfield St. Hospital	Supervisor of Files	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET AND NUMBER
Maryland	Montgomery	Kensington	X	5005 Flanders Avenue

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
David R Hudgel			Minerva Morrow		

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
No		220-54-0023	Springfield St. Hospital Records	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Bilateral Bronchopneumonia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: days

4449

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Gangrene right arm and hand — days

DUE TO, OR AS A CONSEQUENCE OF right innominate artery

(c) Arteriosclerotic Occlusion and thrombosis of the — days to years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

437 X

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☒ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** thot (I) (~~this hospital~~) ottended the deceased from 1-12-68, 19___, to 2-24-68, 19___, that (I) (~~we~~) lost saw the deceased alive an 2-24-68 19___, and that in (my) (~~our~~) opinion death occurred on the date and haur ond from the couses stoted obove, (I) (we) (did) (did not) view the body ofter deoth.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
		☐	☐	☒	2-24-68

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Dr. Hapner	Springfield St. Hospital, Sykesville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	2/28/68	Arlington, National	Arlington, Va.,

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Jos. Gawler's Sons 5130 Wisconsin Av., NW Wash. D.C.	MAR 1 1968	Charles Judge

VR AT5 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02491

CERTIFICATE OF DEATH

02477

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
STella	Blanche	Wheeler	Feb	21	1968	845 P M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 1 YEAR DAYS	IF UNDER 24 HRS. HOURS	IF UNDER 24 HRS. MIN.
Female	Cau.	Jan. 5, 1889	79 YRS.				

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ✓ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
Maryland	USA		CARROLL Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
WestminsTer	CARROLL Co. Gen.	HouseWife	Home

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN, 2,074	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET AND NUMBER
Md.	CARROLL	HampsTead		R.D. 2

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
DAVID		SIX	ELizabeTh		HollenbemY

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
NO	218-09-1104 B	James B. Wheeler	RD. 2 HampsTead

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Thrombosis
4109
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic Heart Disease
DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4201

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from Feb 20, 19 68, to Feb 21, 19 68, that (I) (we) last saw the deceased alive an Feb 21, 19 68, and that in (my) (aur) apinian death accurred an the date and haur and fram the causes stated abave, (I) ~~(we)~~ (did) ~~(did not)~~ view the bady after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS. ✓	MED. DIRECTOR ☐	STAFF PHYS. ☐	22c. DATE SIGNED
John S. Harshey, MD					2/21/68

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
JOHN S. HARSHEY, M.D.	

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town)	(County)	(State)
Burial	Feb, 24, 1968	Greenmount Cemetery	Greenmount	Carroll	Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
John E Hoff	HampsTead, Md.	FEB 26 1968	

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VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02492

CERTIFICATE OF DEATH

02478

1. DECEASED-NAME (Type or print): First Della Middle Virginia Last Witte
2a. DATE OF DEATH: Month Feb Day 7 Year 1968
2b. HOUR: 1:45 PM
3. SEX: female
4. RACE: White
5. DATE OF BIRTH: 4/17/1887
6. AGE (In years last birthday): 80 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.
7a. BIRTHPLACE (State or foreign country): Carroll Co MD
7b. CITIZEN OF WHAT COUNTRY? U S A
8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
9. COUNTY OF DEATH: Carroll Md.
10. CITY OR TOWN OF DEATH: Manchester
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): 40 NORTH MAIN ST.
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife
12b. KIND OF BUSINESS OR INDUSTRY:
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland
13b. COUNTY: Carroll
13c. CITY OR TOWN: Manchester
13d. INSIDE CITY LIMITS? YES ☑ NO ☐
13e. STREET AND NUMBER: 40 N Main St
14. FATHER'S NAME First George Middle Last Myers
15. MOTHER'S MAIDEN NAME First Sarah Middle Last WISNER
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes, give war or dates of service): No
16b. SOCIAL SECURITY NO.: 213-16-0015
17. INFORMANT: Mrs. Edna Stegeet Address: 40 N. Main St Manchester, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Thrombosis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 weeks
4339
Conditions, if any, which gave rise to immediate couse (a), stating the underlying cause lost.
DUE TO, OR AS A CONSEQUENCE OF (b) Generalized Arteriosclerosis — 5 yrs
DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
332X

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☑
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, natify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Manth Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 ar Port 2, Item 18.)
21d. INJURY OCCURRED While at work ☐ Nat while at wark ☐
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street ar R.F.D. No. City ar Town County Stote

22a. I certify that (I) (this hospital) attended the deceased from Sept, 1951, to Feb 7, 1968, that (I) (we) last saw the deceased alive on Jan 25, 1968, and that in (my) (aur) apinian death accurred on the date and haur and from the causes stated abave. (I) (we) (did) (did nat) view the bady after death.

22b. SIGNATURE: W. H Foard M.D DEGREE — ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22c. DATE SIGNED: 2/7/68
22d. PHYSICIAN'S NAME (Type): W. H. FoArd M.D
22e. ADDRESS: 25 N. Main St Manchester, Md 21102

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE: FEB 10, 1968
23c. NAME OF CEMETERY OR CREMATORY: WESTMINSTER CEM.
23d. LOCATION (City ar Tawn) (Caunty) (State): WESTMINSTER, CARROLL, MD.
24. FUNERAL DIRECTOR: James G. Saffell Jr. 25-27 ADDRESS MAIN ST. WESTMINSTER, MD.
25a. REC'D BY REGISTRAR DATE: FEB 9 1968
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the haspital ar attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remave carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar ta burial, cremation, ar removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02493

CERTIFICATE OF DEATH

02479

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
Delia	Bridget	Wooten	2	9	68	1:15 pm

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.
female	white	3/6/90	77 YRS.				

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
Ireland	USA		Carroll Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Rural--Sykesville	Springfield State Hospital	housewife	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Md.	—	Baltimore	YES ☒ NO ☐	2022 Hillenwood Road

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Dennis		Curtin	Ellen		?

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
no	unk.	Springfield Hospital records, Sykesville, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Congestive heart failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: days

4270

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4371

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Chronic brain syndrome associated with senile brain disease with psychotic reaction.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that ~~I~~ (this hospital) attended the deceased from 1/28/ , 1968 , to 2/9/ , 1968 , that ☒ (we) last saw the deceased alive on 2/9/ 1968 , and that in ~~my~~ (our) opinion death occurred on the date and hour and from the causes stated above, ☒ (we) (did) ~~did not~~ view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Naci N. Buyukunsal		☐	☐	☒	2/9/68

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Naci N. Buyukunsal, M.D.	Springfield State Hospital Sykesville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	2/13/68	Baltimore National Cemetery	Baltimore, Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Ullrich Funeral Home Dundalk, Md.	FEB 15 1968	Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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30M REV. 1/68